The

NATION'S HEALTH

a ten year program

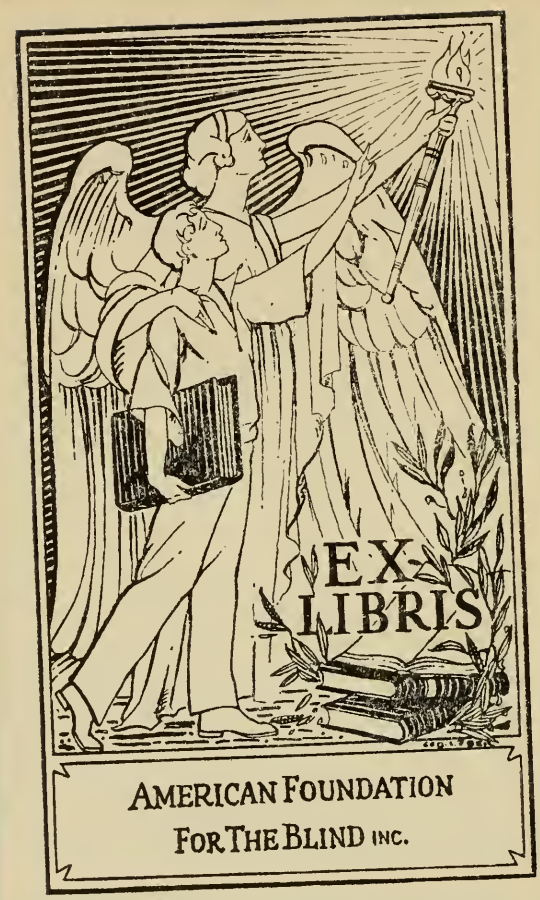
a report to

THE PRESIDENT

by

OSCAR R. EWING

Federal Security Administrator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the nation's health

a report to THE PRESIDENT

by OSCAR R. EWING

Federal Security Administrator

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letter of transmittal

Washington, D. C., September 2, 1948.

My Dear Mr. President: In accordance with your request of January 30, I have prepared a report on the state of the Nation's health, and on plans to raise the national level of health during the next decade. The report, entitled "The Nation's Health—A Ten-Year Program," is herewith submitted.

In preparing this report, I have consulted widely with persons both in and out of the Government. I wish particularly to commend the invaluable work of more than 800 professional and community leaders who met in Washington May 1–4, 1948, to advise with me in the National Health Assembly.

Respectfully,

Oscar R. Ewing

Federal Security Administrator.

The Honorable
The President of the United States

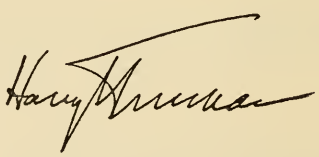
The White House, Washington, D. C., January 30, 1948.

DEAR MR. ADMINISTRATOR: The health of our people is of such importance to our national welfare and security that I wish to make certain that we are taking all possible steps to contribute to its improvement. I have, as you know, repeatedly requested the Congress to enact legislation designed to expand basic health services and to bring them within the reach of all the people. While such legislation is of primary importance, its enactment alone will not assure that we shall reach the highest possible levels of health. The attainment of such a goal requires the cooperation of State and local governments, voluntary organizations, the medical and health professions, as well as all of our citizens working together.

Our people want good health and are willing to work to achieve it. Notable progress has already been made. But I am convinced that we have scarcely scratched the surface and that, as a Nation, we can make rapid progress in the immediate future.

I should like to ask you, therefore, to undertake a comprehensive study of the possibilities for raising health levels and to report to me, at your early convenience, upon feasible goals which might be realized by the American people in the next decade. I should appreciate further any suggestions you may wish to make concerning the most practicable methods of achieving such goals. In preparing this report, you will undoubtedly wish to confer with interested persons both in and out of the Government.

Very sincerely yours,



President of the United States.

The Administrator,
Federal Security Agency.

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acknowledgment

In the preparation of this report to the President, I have had the assistance of literally hundreds of people. The National Health Assembly, which met at my call in early May here in Washington, was extremely helpful. Through the deliberations of this distinguished body, more than 800 leaders from every walk of life and from all parts of the country—representatives of the consumers, the professions, the voluntary and professional associations, the organized health services, hospitals, professional schools, universities and research groups—have given me the benefit of their knowledge and advice.

I wish to express my particular thanks to the Executive Committee which guided the Assembly in its work. The members of the committee.

Rev. John W. Barrett, vice-president, Catholic Hospital Association

Rev. Beverley M. Boyd, Federal Council of the Churches of Christ in America.

Dr. Edward L. Bortz, former president, American Medical Association.

Mrs. J. L. Blair Buck, president, General Federation of Women's Clubs.

Earl Bunting, managing director, National Association of Manufacturers.

Miss Elisabeth Christman, secretary-treasurer, National Women's Trade Union League.

John W. Dargavel, executive secretary, National Association of Retail Druggists.

Graham L. Davis, president, American Hospital Association.

Miss Katherine Densford, president, American Nurses' Association.

Dr. Louis I. Dublin, Metropolitan Life Insurance Co.

Dr. Robert P. Fischelis, secretary, American Pharmaceutical Association.

Judge Jerome N. Frank, United States Circuit Court of Appeals.

Dr. Vlado A. Getting, Commissioner, Massachusetts Department of Health.

Albert S. Goss, president, National Grange.

William Green, president, American Federation of Labor.

Most Rev. Francis J. Haas, Bishop of Grand Rapids.
Dr. Paul R. Hawley, Associated Medical Care Plans.
Miss Frieda Hennock.
Dr. Harold Hillenbrand, general secretary, American Dental Association.
Mrs. L. W. Hughes, president, National Congress of Parents and Teachers.
William Harding Jackson, chairman, Hospital Council of Greater New York.
Eric Johnston, president, Motion Picture Producers and Distributors of America.
Mrs. Albert D. Lasker, president, the Albert and Mary Lasker Foundation.
Mrs. David M. Levy, Citizens' Committee on Children.
Dr. George F. Lull, American Medical Association.
Mrs. Eugene Meyer.
Dr. James L. Morrill, president, University of Minnesota.
Philip Murray, president, Congress of Industrial Organizations.
James G. Patton, president, National Farmers Union.
Mrs. Anna M. Rosenberg.
Dr. R. L. Sensenich, president, American Medical Association.
Earl O. Shreve, president, Chamber of Commerce of United States of America.
Dr. Frank Stanton, president, Columbia Broadcasting System, Inc.
M. W. Thatcher, president, National Federation of Grain Cooperatives.
Jerry Voorhis, secretary, Cooperative Health League of United States of America.
Walter White, executive secretary, National Association for Advancement of Colored People.
Dr. Charles F. Wilinsky, trustee, American Hospital Association.
Dr. Abel Wolman, chairman, executive board, American Public Health Association.

It is my pleasure also to express my deep appreciation to the various units of the Federal Security Agency that have devoted so much time and energy in assisting me in the development of this report. Officials and staff of the Public Health Service were, of course, particularly helpful.

foreword

The central purpose of the program set forth in this report is to promote the highest possible level of national health. Every family, every individual has a stake in this achievement; it is only through promoting the physical, mental and social welfare of all individuals and of all communities that the Nation, as a whole, can advance toward better health.

Such a program calls for action on a great many different fronts. Provision of ample health and medical services everywhere is of course fundamental, but many other factors will make important contributions to our progress.

Our standard of living, the conditions under which people live and work, the food they eat—all affect health. In a broader sense, the strains of competitive living, of financial insecurity, of national security and economic conditions, of discriminatory practices and community rancors—all of these—must be ameliorated if we are ultimately to achieve, for everyone, a full measure of abundant mental and physical health.

To the extent that these factors enter directly into the provision of health and medical services they are considered here, but the province of this report is primarily the provision of medical care and of health services.

Even this more limited scope of the report involves a complex of problems. It was necessary to assess our resources—the manpower, facilities, knowledge and funds used for promoting health. The way in which these resources are organized to serve the people was equally important; the economics of health and medical services necessarily was considered. Public health work—the general services provided by governments—is only a part of the total picture. The private administration of medical care had to be evaluated. In fact, the entire health pattern of the country came under examination.

Necessarily, the emphasis in such an evaluation is upon the gaps in our health programs. This report, accordingly, directs attention to our deficiencies. Past progress, exciting as it has been, is only briefly referred to here. This report starts with our national health as it is today and points the way toward greater progress. The

whole task—surveying resources, estimating our needs, setting the goals—has required the contributions of a great many people from all walks of life.

THE NATIONAL HEALTH ASSEMBLY

The National Health Assembly performed an invaluable service—not only in helping to supply the substance of this report, but in providing a meeting of minds on the Nation's health problems. The hard-working delegates demonstrated that, even in the complex and controversial field of national health, Americans could work together for specific goals and devise mutually satisfactory means to attain them.

Numerous constructive conclusions were reached by the Assembly. The detailed reports and recommendations of the Assembly's 14 panels will be published as soon as possible. They will constitute the report of the National Health Assembly and will serve to supplement this report in considerable detail. A wealth of documentary material will be found in them for the inspiration and guidance of all groups and communities striving toward the attainment of health goals.

This report to the President draws heavily upon the findings of the Assembly, which form the basis of many of the recommendations herein. In a few instances, this report goes beyond the areas of agreement reached by the Assembly or deals with problems not specifically discussed. In some instances, additional recommendations have been considered necessary.

I would like to make it clear that I have weighed carefully every finding and recommendation of the Assembly. To the issue of health insurance, I have given particular time and thought. The Medical Care Section of the Assembly unanimously agreed that "the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people." There was no agreement on the question of national health insurance and my recommendation of such a program must be clearly understood as in no way expressing the views of the Assembly. It took no position, one way or the other, on this question.

The position of the Administration for national health insurance has been stated many times, as has my own. Nevertheless, I have

reexamined the whole matter as objectively as possible—the advantages and disadvantages, including the fundamental conditions which prompted its recommendation in the first place. The arguments that have been made against national health insurance have been carefully weighed and I still find myself compelled to recommend it. After all, we are dealing with human lives and human suffering and anguish. Every year, over 300,000 people die whom we have the knowledge and skills to save. This stark fact proves that the present system is inadequate. By and large, only the well-to-do and, to a certain extent, charity patients get satisfactory medical care. The in-between groups—other than the fairly small portion who are covered by voluntary insurance plans—are the ones desperately in need of better care. I see no possible way to provide funds needed for adequate medical services to these in-between groups, who constitute the vast majority of our people, except through a system of national health insurance.

COMMUNITY ACTION

The success of the National Health Assembly as a forum suggested to me the value of holding similar State and local assemblies throughout the country to exchange information and opinion, and to organize health work.

State and local planning is the only foundation on which we can build toward our national health goals. The entire national program is directed toward providing what communities and individuals require to promote better health. Progress will depend on action by the people in individual communities throughout the Nation; on their initiative, and the urgency of their demand for better health.

They will need to define their requirements, and determine their goals. The follow-through to improve local health opportunities will be the joint responsibility of local, State and Federal Governments and of voluntary and professional agencies.

For technical advice and consultant services, communities can turn to the Nation's professional associations, the medical and public health schools, and to governmental agencies. The Federal Government itself must be called upon to encourage an increase in our national resources for health and to attack the economic problems of providing medical and health services. With the cooperation of

the States, it will help in the financing of many local facilities and services.

All of the help the Nation can give, however, will prove insufficient unless the communities themselves enter wholeheartedly into the work.

The first step, as the National Health Assembly's Section on State and Community Planning recommended, is for people interested in local health problems to get together—as they did in the National Assembly. There, technical experts and representatives of professional and consumer groups met in good will to ask questions about health and medical problems, and to agree on many solutions. Similar local or regional congresses, asking similar questions of importance to their own communities, can make a sound beginning on cooperative study and action.

Local assemblies will find the need to ask, and to answer, such questions as:

1. What is the state of health, and what are the health and medical services in our community as contrasted with achievements elsewhere, and as contrasted with the national goals?
2. What health goals can we attain in the next 10 years on the basis of existing health conditions and medical knowledge?
3. How can we organize our health and medical resources so that every person in our region has access, in health and sickness, to the highest quality of services?
4. What should our State and Federal Governments do to assist us? Our professional societies? Business, industry, and philanthropic institutions?
5. How can we make sure of an adequate annual expenditure of funds to supply those needs?

THE WAY TO OUR GOALS

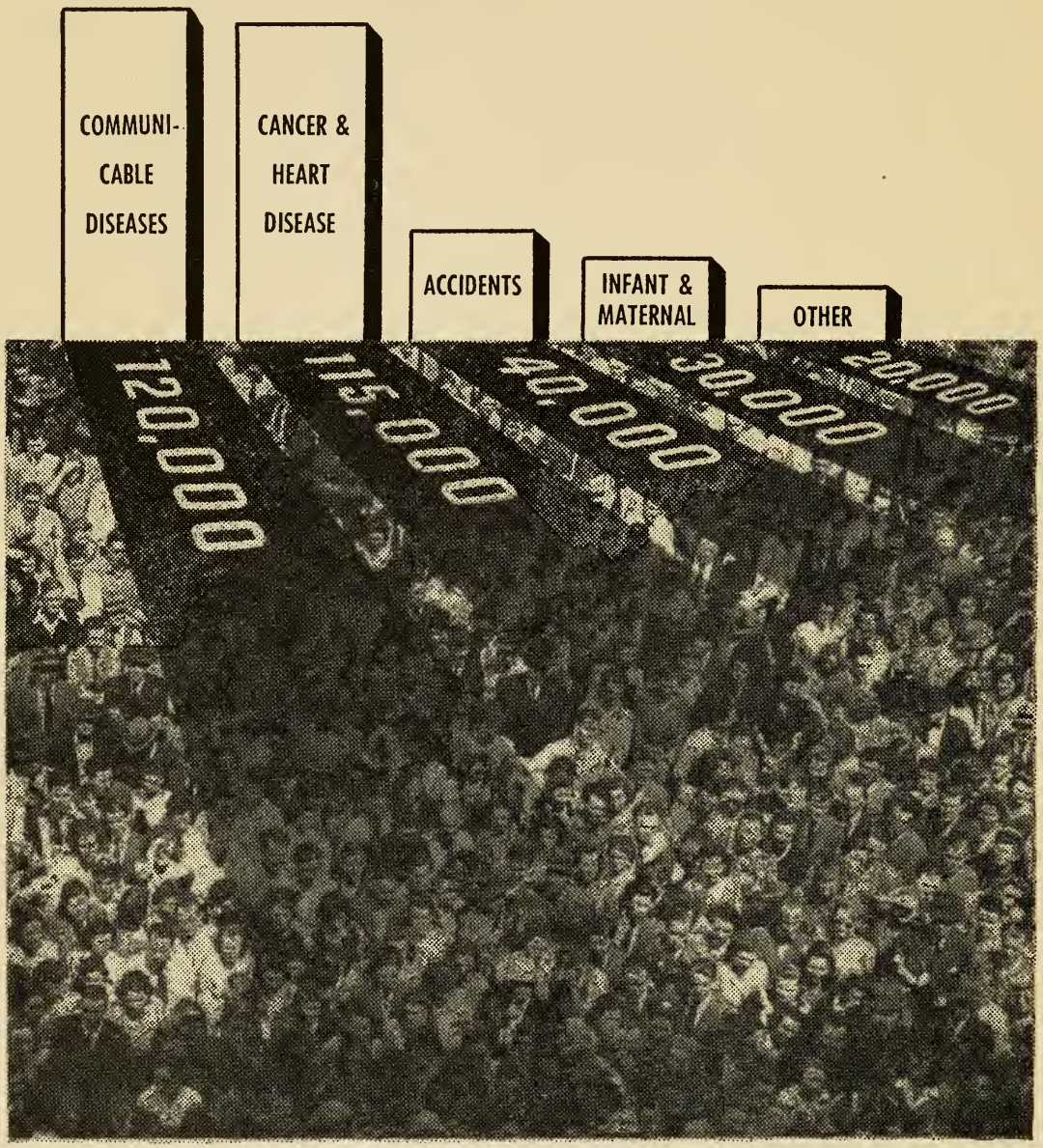
We need to ask these questions and many more. All of us need to ask. Civic, professional, and Government leaders will want to meet together and look into health problems, but so will consumer and social groups, labor and farm organizations, business, and management representatives. Health is everybody's business. Everybody should want and demand for himself, and for those

dependent upon him, the best of health and medical services. He must ask why he is not receiving them and what can be done about it.

The asking of the questions is, of itself, an important effort. All growth starts with that kind of inquiry. Progress comes through the effort to make constructive answers. As a people then, we must get together in every urban and rural community, in every State and region, and organize that unified and democratic teamwork which alone can answer our questions fully in plans and action for health.

GOAL: KEEP THEM LIVING

We have the knowledge to prevent 325,000 deaths each year



The Health of The Nation

During the last generation, the United States steadily improved its health record, but the Nation, and the people, still suffer severe losses through sickness, disability, and death, much of which is unnecessary.

Every year, 325,000 people die whom we have the knowledge and the skills to save.

Every year, the Nation loses 4,300,000 man-years of work through bad health.

Every year, the Nation loses $27,000,000,000 in national wealth through sickness, and partial and total disability.

The record of Selective Service examinations during the war is widely known—5,000,000 men declared unfit physically or mentally for the armed services of their country.

A NATIONAL PROBLEM

No Nation can afford to allow these conditions to continue if it has the means to correct them. Healthy citizens are the Nation's most basic resource. Prosperity and the national security depend heavily on maintaining health at the highest possible levels.

Wasteful at any time, the losses we suffer through ill health are particularly damaging today. The Nation is dedicated to a program of full production and full employment, to the promotion of a constantly rising standard of living. Many nations of the world look to the United States for the leadership and for the production that is their chief hope of survival. It is no exaggeration to say that their future growth and development, as well as our own, is intimately bound up with a high and improving standard of health in the United States.

In estimating the importance to the Nation of good health and adequate health services, we also cannot ignore the fact that the world is not at peace. We are forced to remember what the war did to European peoples and that, in modern total war, the health of the people has become a primary target for enemy action. We

know also that our armed forces create special demands for medical manpower; that a national emergency would throw an intense strain on our entire health system. Fortunately, the steps that we should normally take for economic and social progress are, in matters relating to health, the same steps that we would take to be prepared for a national emergency.

AN INDIVIDUAL PROBLEM

From the standpoint of the people, every national gain will work equally for the individual's good. The value of health to the individual cannot be overestimated. Poor health can deprive people of most of the enjoyment of life and can wreck family finances. The dollar and cents value of being able to work at best capacity is, in itself, enormous. It is an opportunity that should be guaranteed every man.

No man really has that equality of economic opportunity which is the tradition of our American democracy if, through being unable to obtain the health or medical services he needs, he suffers ill health or disability.

It is the Nation's responsibility, and to the Nation's advantage, to do its utmost to insure that all people everywhere attain the highest possible level of health.

Can We Improve National Health?

A concerted effort to reduce sickness and premature death and to promote individual and community welfare will certainly result in worthwhile gains.

These great achievements of the past bear witness to what can be done:

1. Twenty years of life added to the average expectancy of individuals at birth;
2. Conquest of certain disastrous epidemics, which have been virtually eliminated as a threat to health in this country;
3. A generation of stronger, better-fed children; and a larger body of knowledge on the child—his physical, mental and social development—from before birth to the age of six than we have about any other period of human life;

4. A vast storehouse of knowledge about the prevention and treatment of diseases;

5. A sharp reduction in the death tolls from many diseases that were high on the mortality lists of the past.

Contributing to these gains is our present health organization combining local, State and Federal units. We have specialists in various fields of medicine who are unrivaled in skill and competence throughout the world. Many devastating communicable diseases have been brought under control, and improved surgery has saved countless lives.

Probably the most important single reason for these gains is the fact that, during the last few generations, medicine has really come of age. Scientific medicine is newer than the use of electricity. Anesthetics were first used only a short while after the telegraph was invented. Aseptic surgery came in with the automobile. A little over a hundred years ago, many hospitals were little better than pest houses, not the modern workshops of scientific medicine they have become.

THE PROMISE

These facts underscore the tremendous gains that have been made. But the record, good as it is, leaves plenty of room for improvement. Of more than 3,800 deaths that occur daily in the United States, nearly 900—about 23 percent—are preventable.

Much of the sickness that cuts down the efficiency of the Nation's working force can also be prevented. Some 1,600 industrial groups have, for years, been seeking improved health among their employees by providing them with health and medical services and by improving the conditions under which they work.

In a survey* of results, these industries reported a 63-percent reduction in occupational diseases, a 30-percent reduction in absenteeism due to sickness. These ratios are not directly applicable to the population as a whole, but they do indicate marked gains in health. There is no question that parallel gains could be obtained among the population at large by provision of, and ready access to, adequate health and medical services.

*Health on the Production Front, National Association of Manufacturers, New York, January 1944.

What Kind of Services Will Be Required?

Clearly, it is necessary, first of all, to define the types of services and care that are needed—those that must be made available to every person in the United States if we are to attain the highest level of national health.

Here they are:

Medical and Dental Care

The primary requirement is that every area should have enough medical manpower of all kinds to meet local needs and that their essential services should be available to everyone in a health center or hospital clinic, in offices, the home, or wherever care is needed.

A Healthful Community

Every town, city, rural area should be guarded by a well-staffed public health department against the spread of diseases through sewage, water, milk, food, insects, animals, poisonous fumes, and other environmental hazards.

A Community Clinic

The need for community clinics will vary with the facilities that exist in the area, and with the access that all people have to its services. It will be particularly important for smaller towns and rural areas to have a publicly owned facility in which both private medical workers—physicians, dentists, nurses, and supporting personnel—and public health workers can have offices and work together for the provision of full preventive, diagnostic, and consultation services.

A Community Hospital

This type of hospital is just what its name implies, a hospital fitted to community needs, large enough to care for all births and other ordinary hospital needs among the population it serves. Such a hospital will be most important in rural areas, or small towns such as county seats, and should be so placed that no one in the county is more than an hour's easy travel from such a hospital; clinics, of the type described above, should be even more conveniently placed.

A District Hospital

Urban centers should have larger hospitals to which local residents have direct access, and to which people from smaller surrounding communities or rural districts can be referred to receive services not available in community hospitals—the services of surgeons, pediatricians, orthopedists, obstetricians, radiologists, and of the clinical laboratory. In the district hospital, complete diagnostic services would be available, as would treatment for serious pathological conditions.

Special Hospitals

Under this heading fall a wide variety of health facilities, institutions for all types of chronically ill patients, closely associated with general hospitals. Nursing and convalescent homes come in this category. Special home care for invalided and aged persons should be provided. Rehabilitation, including vocational training, also should be available in general hospitals, special centers, and related institutions.

A Medical Center

There should be at least one medical center in every State, preferably associated with a medical school. In the center, medical research would be carried on and medical personnel trained. It would provide refresher courses for doctors of the region and provide extension training to keep them abreast of medical science and latest techniques. The center, moreover, should work with other hospitals and local doctors to make available the latest knowledge, equipment and methods, and would receive patients from surrounding communities for highly specialized care and study.

Coordination

Even a full range of the essential services and care outlined here will fail in its total purpose of improving health unless all of them are organized for the closest teamwork to achieve the best possible services for the community as a whole.

A Prepayment Plan

A system of insurance should make it possible for everyone to have comprehensive care without worrying about meeting sudden bills out of current pay, without exhausting savings or going into debt, and without being dependent on charity care.

The goals we must set become apparent in this listing of what the individual needs to promote health and to take care of himself and his family in sickness. The procedure for setting precise goals also is clear.

1. We must determine what we need in resources and facilities, in organization and in services;
2. We must determine the size of our specific deficits—how far we are from meeting our needs;
3. We must decide the best methods of eliminating these deficits and providing for our needs;
4. Having fixed on these long-range plans, we must set up our feasible 10-year goals to take us as far as possible toward the ultimate realization of providing enough health and medical services for everybody, everywhere.

Assumptions

The provision of health and medical services and the pursuit of health knowledge are not the only requirements for national health.

In addition to our special efforts for the attainment of health, we must assume contemporaneous and parallel efforts to assure: (1) A steadily rising standard of living, assuring better nutrition, recreation, and other contributions to healthful living; (2) better educational systems—in number and quality; (3) increased benefits for the aged and permanently disabled so that their minimal essential economic needs are provided for; (4) adequate housing for the people of this Nation—a fundamental requirement; and (5) increased understanding on the part of the people of the benefits of scientific medicine and public health methods.

Limitations

It is important to point out certain limiting principles that must apply to any national program. Realizable health goals will vary, not only among individuals and groups, but among States and communities. No single set of health goals can be reached by all of the people and in all parts of the country in the next 10 years. Plans for the attainment of health goals must be varied according to the relative needs and resources of various parts of the country.

How Can We Measure Adequacy of Resources?

Within the broad frame of reference that has been outlined, we can establish the basic criterion against which to measure the adequacy of our health resources and services. The sole basis is, and must be, the people's fundamental need. Nothing less than meeting actual needs for everyone, everywhere, will guarantee the Nation the highest possible level of health.

In the past, our economy has measured the adequacy of health and medical services generally in much the same way it would estimate the adequacy of supply of any commodity. The criterion has been, substantially, "Is there enough to satisfy the purchasing power of the consumers?"

There are exceptions to this rule, of course. Governments generally provide for the very poor, and for special categories of people such as those mentally ill or suffering from tuberculosis; for veterans of our wars and merchant seamen. Philanthropy has made its great contribution. Despite these exceptions, the general rule holds good. The quality and amount of care given to the needy and available to all depend upon the income level of the community in which they live. In wide areas of the country, low per capita income has been an important factor in creating local scarcity of doctors and hospitals.

On a national basis, the number of medical schools in the country is greatly influenced by the demand for their graduates created by national purchasing power. This is equally true of the number of students who enter medical and other health schools—more will enter training and more training facilities will be developed as the purchasing power for their services increases.

This condition is natural and inevitable under a pay-as-you-must system of health services. In itself, it constitutes one of the major difficulties which must be overcome if we are to lift the national health far above present levels. Plainly, then, if we are to move toward our ultimate goal, we cannot continue to use the purchasing-power demand as our exclusive criterion of the adequacy of supply.

We must measure our resources and services against the actual health and medical needs of all the people, without regard for their individual ability to pay.

Our Resources for Health

When we use the actual needs of the people as a gauge, the conclusion is inescapable that our national provisions for health, our resources, and the way in which services are distributed are in many respects totally inadequate to the requirements of the United States' 143,000,000 people. This situation is incompatible with our position as the world's leading democracy, and our total effort for health is completely out of pace with our expanding economy and with our national aims for the welfare of the people.

We have not enough medical manpower, not enough health facilities, not enough research. Moreover, the Nation's health resources, as they exist, are not used with maximum effectiveness; and the lack of any systematic method of health financing presents an extremely grave handicap to all progress. (See page 10, Conclusions of the Report on Key Health Problems.)

THE PENALTIES

Before detailing the national health program, aimed at correcting these deficiencies, it is pertinent to examine the suffering they cost the Nation.

Each year, 1,400,000 people die in this country. Obviously, most of these deaths cannot be prevented. The individuals have reached an age when death is inevitable; or they die because of unavoidable accidents or catastrophes, or—the largest group—because today's medical science does not have the means to save them.

Some of the deaths, however, do not have to occur. If we had enough medical manpower and hospitals everywhere, and a better system of financing care, if public health work were fully effective everywhere, if our scientific knowledge were greater and better harnessed and distributed, our present total of 1,400,000 deaths could be sharply reduced.

It is, of course, impossible to arrive at any precise estimate of the exact number of people whose lives we could save each year. Certainly we could prolong the lives of several hundreds of thousands of persons each year.

For example, out of the 170,000 deaths from communicable diseases, including pneumonia, that occur every year, we should be able to save at least 120,000 with the knowledge and skill that we now have.

Of more than 600,000 deaths from cancer and heart disease each year, we should be able to prevent 115,000.

Similarly, of the 100,000 deaths yearly from accidents, the fuller use of safety measures and better education should permit us to save perhaps 40,000.

Infant and maternal deaths have been reduced sharply during the last two decades, but we have fairly conclusive evidence that at least another 30,000 of the 110,000 who now die yearly could be saved. This is in addition to the 5,000 deaths from communicable diseases and 12,000 deaths from pneumonia among infants under a year—included in the estimate on communicable diseases above—that could be prevented.

Finally, we could probably save in the neighborhood of 20,000 lives from the remaining group of several hundred diseases which claim 400,000 lives a year.

These are some of the lives we could save if we were able today to assure every person in the country that he would be able to receive the health and medical services that he needs. All told, these preventable deaths total 325,000. They are not, of course, the full measure of what we fail to do in health. There are crippling diseases, not necessarily fatal, which take a heavy toll—rheumatism, for example, and mental diseases. Suffering and heavy losses may be caused by many other ailments that do not result in death.

Nevertheless, the total of preventable deaths does provide us with a bench-mark against which we can measure our efforts in the health field. It is a challenge to all who are concerned with improving the Nation's health. It sets a goal, expressed in terms of saving human lives, that we should strive to achieve. It may not be attained in a year, perhaps not in 5 years or more. This year and every year, however, we can prevent some of the 325,000 deaths that would be averted under improved health conditions.

The promise is that if we work out an effective health program, we should save increasing numbers of people every year. The threat is implicit in the promise—unless we do move aggressively to prevent needless deaths, their total number may increase.

Conclusions of the Report

Manpower

Our health manpower—physicians, dentists, nurses and supporting personnel—is insufficient in numbers and so poorly distributed that large sections of the country and many millions of people are without even minimum health and medical services. We have only 80 percent as many physicians as we need and even greater shortages of other medical personnel.

Moreover, we do not have enough medical colleges, training schools and teaching hospitals to close the gaps between need and supply at any time in the foreseeable future. The financial condition of most training institutions is such that they have great difficulty in maintaining standards of quality and, without help, can rarely even consider increasing their production of needed manpower.

Hospitals

Our hospitals and other health facilities have not kept pace with our needs. We have only about 50 percent as many acceptable hospital beds as we require. Only through the recently enacted Federal Hospital Survey and Construction Act has there been any Nation-wide effort to plan construction on a State or a regional basis. For the most part, hospitals have been planned, constructed and operated without reference to the economic and efficient provision of the wide variety of services expected in modern institutions. They operate mostly as independent units, without reference to one another, without arrangements to provide their patients, through integration with other institutions, the services which they individually lack.

Local Organization

The Nation's health resources are not used at full efficiency. Public and private services alike have for the most part grown up without effective plan. Some 18,000 local political units provide some form of health and medical services. About 20,000 voluntary

health organizations and some 6,000 hospitals are operating in different communities, each segment generally independent of the rest. The lack of organization in many communities throughout the country makes it impossible for them, and for many of their citizens, to obtain even those services that are available in their regions. There are grave shortages in such fundamental provisions as local public health departments; where they exist, they are largely understaffed and underfinanced.

Research

Our search for new knowledge about man and his human need is feeble compared with our search for knowledge that will contribute to material wealth. Nationally, we spend more than $1,000,000,000 on all types of research, of which industrial and military investigations constitute the bulk. Only a little more than 10 percent of this total is devoted to medical and related sciences.

Individual Cost of Care

Perhaps the basic lack of our entire health effort is the absence of any method that would permit the individual, regardless of the level of his personal income, to obtain the kind of services he needs to achieve better health.

A scant 20 percent of our people are able to afford all the medical care they need. About half our families—those with incomes of $3,000 or less—find it hard, if not impossible, to pay for even routine medical care. Another 30 percent of American families with incomes between $3,000 and $5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness.

For the community, this lack of purchasing power helps to limit the number of doctors and other personnel who will practice there. Equally, it places high barriers in the path of building up adequate health facilities.

Methods of Meeting Deficiencies

Confronted with our inadequacies in health facilities and resources, and with what they cost in needless deaths and suffering, the Nation has clear alternatives:

One, to continue with the present general pattern, with chief reliance on slowly increasing economic levels and consequent increased demand to spur expansion of services;

The other, to strike out boldly but with careful planning, to bring our health resources quickly into line with our national and individual needs.

If we continue in the present pattern, it is true that there will be gradual improvement in some parts of the country but in general the gains will come in those areas which already have a relatively high level of health services. The present impoverished and underprivileged districts will lag far behind. New gains may be expected through the progress of science, but the application of these discoveries will be slow. The development of the Nation's health services will be left at the mercy of economic cycles as it has been in the past.

Under these circumstances, minimum effective demand for services—not by any means commensurate with people's actual needs—will determine their level of adequacy. Services will approach adequacy only in those areas where there is ample money.

There are many indications that this alternative will never bring us to the goal of adequate Nation-wide health services. National action is necessary. The financial difficulties of hospitals, medical colleges, and other training schools throughout the country are indicative. Many towns and communities are limited by local levels of income.

The finding of the National Health Assembly's Section on Medical Care that only through insurance could most people really afford proper medical care is a clear recognition of this national situation.

In the face of these and the other proofs given in this report that further rapid improvement in national health can be achieved only by concerted effort, and that the need for increased Federal action is imperative, I have

reached the considered conclusion that more extensive and efficient Nation-wide planning is the only effective way to accomplish a significant betterment in national health.

PATTERN FOR ACTION

It is scarcely necessary to emphasize that the Federal Government cannot alone meet the full needs of the situation. Federal expenditures, professional help, surveys, and planning are key resources for improving health, but they are not the only keys.

Success in our efforts for health will depend ultimately not only on Federal action but also on individual, community and State achievement, and upon the thorough and wholehearted cooperation of all interested groups and individuals. The only effective pattern for raising the health level of the Nation calls for combined Federal, State, and community effort.

Community Role

Communities will fulfill their role by raising the levels of community health with the means that they have at hand, and by utilizing fully the new resources supplied by Federal and State programs. Many communities could increase their financial contributions; nearly all could do more to organize their services for effective, coordinated effort. Programs of community-wide health education, immunization, and improved sanitation, for example, are well within the means of many communities that neglect them. The operation of existing hospitals could be linked through coordination of resources and services so that the advantages of great medical centers could become available throughout a region. Local tax levels often could be increased to employ more adequate local public health staffs and more school nurses, and funds raised to build and support community health centers and diagnostic clinics.

Moreover, communities can assist in all phases of the national and State efforts by thorough cooperation and by pressing, through democratic channels, for action in those fields of health which are beyond their immediate jurisdiction.

State Role

Communities will be handicapped in much that they attempt to do for health, unless there are energetic support and leadership from State organizations and State governments. The difference

this can make is apparent in those instances where State leadership has inspired marked improvement in health and medical services, and in health conditions. In North Carolina, for example, the State government is taking the lead in encouraging the building of hospitals in areas where facilities are lacking or inadequate, by contributing up to half of total building costs under the Federal Hospital Construction Act. At the other extreme, some States are making no contribution at all to the building of hospitals and health centers and, as a result, local communities—even the poorer ones—must carry the full non-Federal cost of hospital construction.

Moreover, many health problems cannot be dealt with exclusively by the local community, and the State must serve as the planning and assisting agency. It can help basically by supplementing the financial strength of the communities and by giving technical aid as well. There is increasing use of the technique of subsidies and grants by States to local areas in many phases of health work. The extension of this pattern is highly desirable.

The Federal Role

Even with the best that local communities and States can do, it will be necessary for the Federal Government to continue to give assistance through national programs and by use of national resources. The role of the Federal Government in health should include:

1. Filling the gaps in which other levels of Government and other groups and agencies cannot, or do not, function and where the national interest and responsibility demand action;
2. Providing leadership, demonstrations, and, when necessary, services in fields of national importance which are neglected or where other action is likely to continue to be inadequate; and
3. Taking affirmative and constructive action in those fields in which it stands in relation to the States as the States do to their local communities.

Specifically, the Federal Government will find it necessary to assist in providing and distributing sufficient resources and services to help build and support adequate hospitals and other facilities, to help develop medical manpower of all kinds, and to aid State and local health departments. The methods used will be special pro-

grams and Federal subsidies, adapted to specific needs, as part of the total health program.

Federal activities, in recent years, have included increased emphasis in four areas:

1. Federal grants to the States for public health work in general, and for special programs;

2. Federal grants for research outside of Government institutions, as well as direct participation in medical and related research in its own laboratories;

3. Direct Federal action to control communicable diseases that present special problems, such as the work done by Federal control teams operating out of the Communicable Disease Center at Atlanta, Ga.;

4. Federal activity in connection with control of chronic and degenerative diseases, in contrast with the previous concentration on communicable diseases, as typified by the authorizations under the acts on mental health, cancer, and heart diseases.

Setting Basic Goals For the Health Program

The emerging pattern of community-State-Federal cooperation for improved health provides the framework in which the following basic goals of the national program are drawn up:

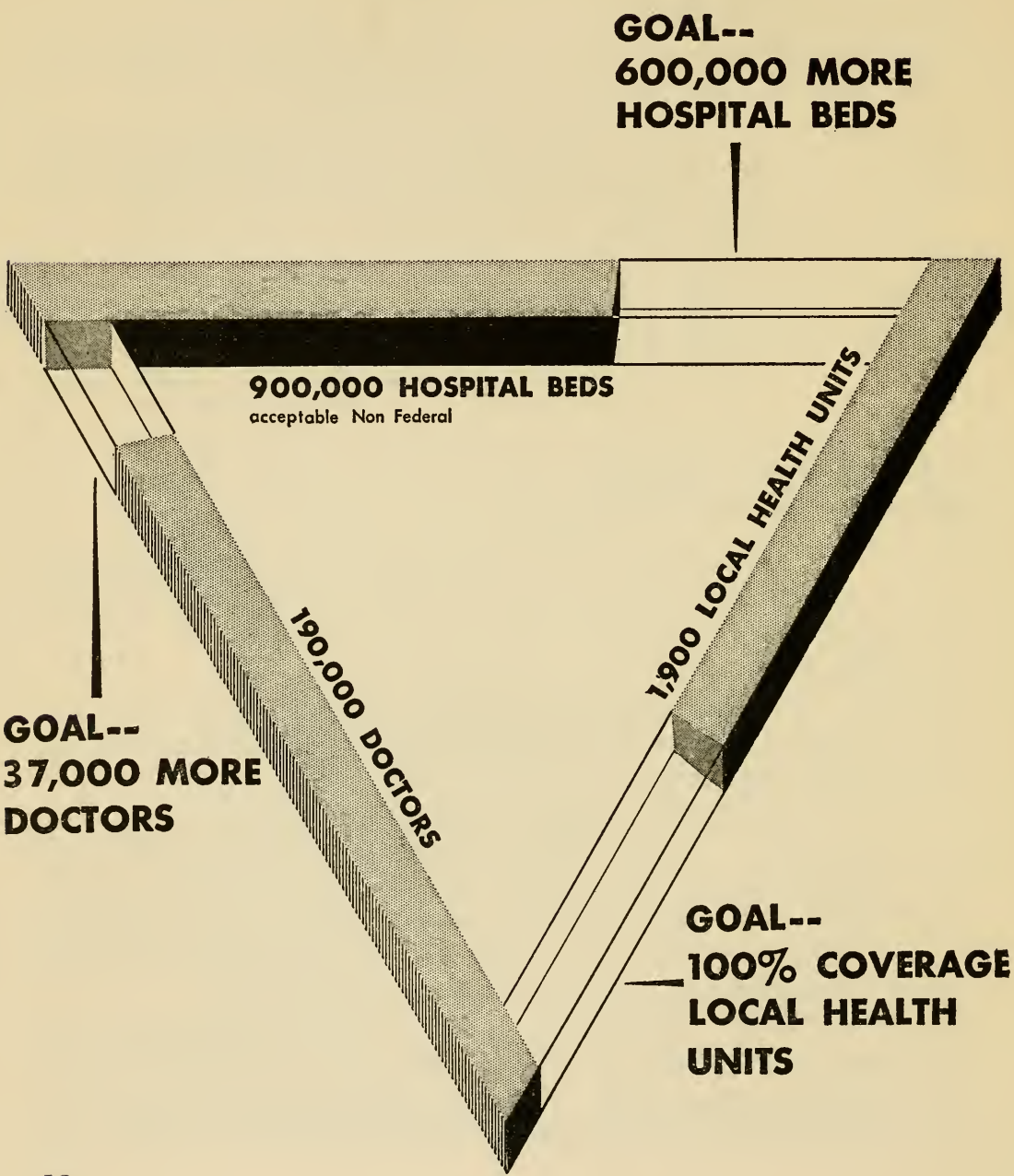
MANPOWER

Our goal for professional health manpower is to assure that there are enough of all categories everywhere to meet the people's need. Specifically:

To increase sharply our total professional manpower through training programs and through financial and other support; to expand medical colleges, training schools and teaching hospitals and to establish new ones until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 percent.

The expansion of training schools, at an average rate of not less than 5 percent per year in annual production, should accomplish the following by 1960: (1) Increase our present supply of 190,000 active physicians to 227,000; (2) increase our present sup-

GAPS IN OUR HEALTH SERVICES
Feasible goals for 1960



ply of 75,000 dentists to 95,000; (3) increase our present supply of 318,000 nurses to 443,000; (4) increase our supply of other supporting personnel by comparable proportional amounts.

HOSPITALS

Our goal for hospitals is to assure that there are enough beds of all kinds everywhere to meet the people's needs, to finance their operation so that they may give the highest quality service, and to unite hospitals and community health centers into regional chains so that the most remote areas will have full access to the most modern medical science. Specifically:

To double the number of acceptable hospitals beds as rapidly as possible, certainly within 15 years, and, at the least by 1960, to have added 600,000 beds to our hospitals, and built such additional health centers and auxiliary facilities as state-by-state surveys have shown to be necessary throughout the country.

This can be accomplished (1) by doubling present building under the Hospital Construction Act for the next 3 years and, after that, by increasing appropriations progressively so that the required total is reached; (2) further, by increasing in 1949 the percentage of the Federal contributions and by encouraging the States to make sufficient contributions so that impoverished areas, which also are the areas of greatest need, will be able to finance their smaller share of total costs; (3) further, by assuring partial Federal financing of operation and maintenance, beginning in 1949, so that inadequate income will no longer constitute a barrier to building hospitals in areas of greatest need.

LOCAL ORGANIZATION

The States and communities themselves ultimately will set their own multiple goals for carrying out their parts of the program for better health. Such programs should include efficient operation, or establishment where they do not exist, of citizen health councils in every State and community throughout the Nation. These councils—planning-action groups of professional, civic and consumer representatives—should survey local needs, plan to meet them through coordinated action and through organization of local health services, then carry through to see that everyone has access to the health and medical services he needs.

Equally, each community should have a local health unit with a full-time qualified staff adequate to the needs of the population, and to the special problems of the community.

The Goal:

To provide Federal assistance by counsel, demonstration and other means for the establishment of citizen health councils in every State and community;

To provide Federal assistance in establishing and maintaining adequate local health units everywhere; to assist in increasing and improving the training of public health workers to the end that their numbers shall be doubled.

INDIVIDUAL COSTS

Our goal here can be no less than the removal of any economic barrier between the individual and his access to whatever health or medical services he needs. Everything else that is done to promote national health will be virtually canceled if millions of the people are barred from health because they are unable to pay for it out of pocket.

The Goal:

To provide that all people shall have access to such health and medical services as they require through a system of insurance covering the entire population.

All our analyses of the problems of health have brought us again and again up against a single stone wall barrier—the inability of millions of the people to meet the costs of health services. Elsewhere, I have devoted a full chapter to a careful weighing of the issues involved in this matter of insurance, and to possible alternative proposals. So far as I can see there is no alternative that offers a reasonable chance for success if we are genuinely to make a strong effort to raise the levels of national health.

For this reason I am compelled to urge, as strongly as I know how, that the Congress enact, as President Truman has recommended, a system of Government prepayment health insurance in the terms in which it has been mapped out in chapter 4. No agreement was reached at the National Health Assembly with respect to national health insurance and hence this recommendation is not based on any action of the Assembly.

RESEARCH

The importance of research to medical progress cannot be overestimated. Without the advances in knowledge and skills that research gives us, we cannot conquer or control diseases; we cannot promote better health.

As in every other area of national health services, the major needs in research are for more manpower and funds. These problems, and others of medical and related sciences, were carefully explored and reported by the President's Scientific Research Board in 1947.* Its recommendations remain the best plan for a research program that we can formulate at this time. The National Health Assembly's Section on Research reported the same deficiencies.

Gaps in Research

It is important to point out some of the specific needs of medical research and the major gaps in health knowledge which must be closed as rapidly as possible. The shortages in personnel and facilities make doubly urgent our efforts to direct research into those areas of greatest national importance.

We need more fundamental research—inquiry into the basic nature of man and his functioning. All progress ultimately stems from this type of research. Since the darkening of many European laboratories, on whose work we chiefly relied in the past, our need is even greater. The President's Scientific Research Board recommended that about 20 percent of all research funds should go for thorough basic research. We should follow this pattern in medical and allied research.

Federal support is particularly needed for long-term research. Only investigation sustained throughout the years can bring us the information we need in psychiatric research, in studies of the aging process in man, chronic degenerative diseases, spastic conditions, congenital deformities and social phenomena influencing health. Scientists both within and outside of Government have for many years pointed out that only the Federal Government can provide the continuity, the Nation-wide coverage, and the stability required in this field.

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*Science and Public Policy, Washington, D. C., 1947.

The Goal:

To increase our investment in medical and related research as rapidly as scientists can be trained until total national research is adequate to keep pace with our expanding needs. By 1960, Federal non-military research should reach a total of $80,000,000 to $100,000,000 if enough qualified scientists are available.

Meantime, the Nation should direct research into those channels where the greatest amount of work is needed so that our limited research manpower is employed to the greatest social and economic advantage; and

Further, to increase our supply of scientists as rapidly as feasible, through special emphasis in our efforts to increase our supplies of all medical manpower.

Special Programs To Promote Health

Our basic health needs will be supplied by meeting the goals already set forth. However, no effort to raise the levels of national health will be complete without special effort in certain areas of increasing importance. These include the fields of mental health, chronic diseases and the aging process, rehabilitation of the disabled, and child and maternal health.

MENTAL HEALTH

Half of the patients in our hospitals on any given day are victims of mental disease; 150,000 more are admitted every year. Many of our social problems—crime, delinquency, divorce—could be greatly relieved by an improvement in our mental health status. Our deficiencies in this field are massive—in manpower, hospital facilities, and clinics.

The Goal:

To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; to expand manpower and facilities for both preventive and curative work throughout the country.

HEALTHY MATURITY

The program to promote better health among the adult population, and especially among those above 45, gains a special urgency from the increasing average age of our population, and the social and economic implications of this development.

Our main effort toward health for this group must be to control chronic diseases, which, besides causing nearly three-fourths of all deaths every year, are the reason that about 2,500,000 of our people are invalids and probably four times as many are partially disabled.

The Goal:

To enable everyone in the Nation to enjoy a healthy, active and productive maturity, by controlling chronic disease—the greatest single barrier to achievement of this goal—and by relieving other physical and mental problems of adult life.

To increase the research into chronic diseases and the aging process until the investment reflects the social importance of these conditions;

To increase the facilities in hospitals and related institutions to balance the need, and to arrange for the supplementary services needed by the 70 percent of all chronically ill who can be cared for in their own homes.

REHABILITATION

We have only started to meet our national needs for rehabilitating those who have been disabled by disease or injury.

The Goal:

To provide rehabilitation services for the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the most nearly normal life and work of which they are individually capable.

MATERNAL AND CHILD HEALTH

The importance of child and maternal health to the Nation needs scarcely be stressed. We have made tremendous strides in this field, but much more remains to be done.

The Goal:

To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care, and social, psychological, and health services for all children and mothers in childbirth wherever they live and whatever their race or income.

Unfinished Business Of National Health

Our program for national health must also lay special stress upon fields where progress has been great, but where extra effort can still pay large rewards—the unfinished business of health. Accident prevention is one of these fields: the others include sanitation; control of venereal disease and tuberculosis; and better nutrition.

ACCIDENTS

The United States has one of the highest accidental death rates of any nation. As a cause of death, accidents are surpassed only by heart disease and cancer. They disable tens of thousands each year and are responsible for about 10,400,000 injuries. The cost to the injured in medical treatment and lost wages amounts to $3,000,000,000 annually. Property damage, overhead costs of insurance, and indirect costs incidental to these accidents add another $3,400,000,000.

In 1946, there were 98,000 deaths in the United States from all types of accidents. The causes, in round numbers, were:

Motor vehicle accidents	33,000
Falls	23,000
Drowning	5,000
Burns (except conflagrations)	5,000
Conflagrations	3,000
Railway accidents	3,000
Other accidents (including industrial)	26,000

Effective campaigns have already demonstrated that deaths from accidents can be greatly reduced. The traffic accident death rate of children 5 to 14 years old, for example, was reduced 33 percent between 1930 and 1946. During the war the combined efforts

of the War Shipping Administration and the Navy Department cut the death rate in shipbuilding industries by 30 percent.

Reducing accident hazards will undoubtedly further limit the toll. Accidents can also be cut down by special attention to safety measures in housing, and building codes; by city and State enforcement of standards for industrial plants, schools, public buildings, and institutions.

SANITATION

Community sanitation is the engineering method of attacking many of the preventable or controllable diseases. It depends upon three basic requirements:

State laws and local ordinances which set high standards for water, milk and food supplies, sanitation of public places, and elimination of disease-bearing animals and insects;

Well-trained State and local staffs of public health engineers and sanitarians to maintain standards, instruct responsible persons, and inspect establishments; and

Enforcement of laws and ordinances, promptly, fully and without favor.

Our national task of sanitation is far from complete. Twenty percent of the fluid milk sold in this country still is not pasteurized. Eradication of insect-borne diseases still lags in spite of the new and tremendously effective insecticides.

Considerable deficiencies in water and sewerage systems have been revealed by a two-year survey that covered a large proportion of the urban and rural areas of the Nation.* Over 2,000,000 persons in 5,700 communities of over 200 population have no public water supply system; 79,000,000 in 15,000 towns and cities have systems needing extension or improvements. In rural areas, only 12,000,000 persons are adequately served; 27,000,000 need new or improved water supplies.

Nine thousand towns and cities, with a total of 6,000,000 population, need complete sewerage systems; nearly 10,000 cities and towns with almost 80,000,000 persons need improved systems; only 6,500,000 live in places where systems need no improvement or expansion. In the rural areas, 6,000,000 have satisfactory disposal

*Nation-Wide Inventory of Sanitation Needs; Supplement No. 204, Public Health Reports, Federal Security Agency, April 1948.

systems; the homes of 33,000,000 persons require new or improved systems.

Thanks to the survey which has revealed these deficiencies, we know our full needs in sanitation accurately for the first time. They are enormous. Complete protection throughout the country would require a total expenditure of $7,700,000,000 at present prices—$2,200,000,000 for water works, $3,700,000,000 for sewage disposal systems, $166,000,000 for garbage disposal facilities and $1,600,000,000 for all types of sanitation facilities—such as septic tanks, privies and pure-water sources—for rural homes.

The task of providing the necessary sanitation facilities to protect the health of the people at present devolves almost exclusively on local communities and States; in the case of rural sanitation, largely upon individual home owners. The greatest needs are in the smaller communities, which will be least able to meet the costs of adequate sanitation. This is clearly a situation in which the State and Federal Governments have a fundamental interest.

The Eightieth Congress recognized part of the Federal responsibility by enacting Public Law No. 845, which provides for loans to local governments—$22,500,000 a year for each of five years—to assist in building treatment plants to reduce the pollution of rivers and streams. This act makes only a beginning upon the total sanitation job that remains to be done, but in view of the inflationary pressures which exist in this country today and the shortages of manufacturing facilities and trained personnel, it probably represents the most that is feasible at this time. In the future, certainly by 1960, loans and grants for elimination of water pollution, for garbage disposal, and for rural sanitation should total about $400,000,000 a year.

VENEREAL DISEASE AND TUBERCULOSIS

The national programs against venereal disease and tuberculosis—initiated in 1938 and 1944 respectively—have now reached a stage at which, with one more intensive, sustained drive in every part of the country, we can reduce these diseases to the minimum now attained for smallpox and typhoid fever.

The Federal Government's cooperative programs against venereal disease and tuberculosis, administered by the Public Health Service, supply funds, expert consultants, equipment and drugs to

every State and community in the land whose health agencies undertake to knock out these age-old killers.

If communities and States will make full use of these services, syphilis could, within 10 years, be virtually eliminated at least as a cause of death; tuberculosis could be pushed down out of the list of "10 most frequent causes of death."

NUTRITION

Despite our progress in acquiring knowledge about nutrition, people are still dying from the effects of nutritional deficiency. The widespread effect of inadequate diets is evident in poor resistance to disease.

It is necessary to increase our knowledge in certain directions: (1) To develop satisfactory methods of appraising nutritional status of representative population groups; (2) to discover all human nutritional requirements; (3) to identify more clearly the effect of different levels of nutrition upon the degenerative diseases; (4) to develop improved methods of measuring all nutrients; and (5) to understand the functioning of nutrients in the body.

Financing the Health Program

The program presented in this report is, I am convinced, the least that the Nation can undertake to satisfy the basic health needs of the people. The record shows clearly that we are doing much less than we could; much less than we ought to do. The prevention of needless human suffering is a challenge that this Nation cannot ignore. Beyond that, bad health takes an economic toll that no Nation can long afford.

Clearly, expansion of health and medical services will cost more money. People will have to spend more, as will local and State communities and governments; so will the Federal Government. Before the details of this increased expenditure are estimated, it is important to see what ill health costs the Nation in actual dollars-and-cents losses.

Sickness and disability cut down a worker's earnings. Equally the sick man's inability to work on certain days reduces the Nation's total production—the number of automobiles, the amount of food, the operation of essential services—by the amount that the worker would have produced had he been well. These economic facts give us a basis for estimating the loss.

The value of all goods and services, including wages and salaries paid, amounted to $230,000,000,000 in the United States last year. About 60,000,000 people were employed, so each one produced an average of about $3,800 of the total. By applying this figure to days absent from work because of illness, total or partial disability, we can get a rough idea of our national losses.

Short-Term Sickness

The category called "short-term sickness" includes all absences because of sickness or injury that last from one day to six months. During 1947 the total loss of time from these causes averaged six days per worker.

At 1947 rates of production, short-term sickness cost the Nation at least $5,000,000,000 in lost production and wages.

Incapacitation

A sickness or injury that keeps a worker away from his job for six months or longer is classed as a total, though not necessarily a permanent, disability. About 3,000,000 workers were incapacitated

in this way during 1947 because of chronic diseases, accidents or other causes.

At 1947 rates of production, their disabilities cost the Nation $11,000,000,000 in lost production and wages.

Partial Disability

Millions of workers suffer partial disabilities which do not keep them from the job, but which nevertheless do prevent them from working and earning at full capacity.

The total loss from such causes is difficult to estimate, but about a third of all those thus partially disabled would normally be full-time workers. The statistics on workmen's compensation and on disabled veterans indicate that the annual loss may be as great as that for sickness and total disability combined.

It is conservative then to estimate that, for 1947, the loss from partial disability is at least equal to that from total disability alone—$11,000,000,000 in lost production and wages.

The National Loss

On this basis the total losses for the Nation in 1947 were:

Causes	*Annual loss*
Short-term sickness	$5,000,000,000
Incapacitation	11,000,000,000
Partial disability	11,000,000,000

The nation thus lost $27,000,000,000 during 1947 in potential production and wages through sickness, partial and total disability.

An Additional Loss

We have not, in these calculations, taken into account the losses occasioned by premature deaths that may reasonably be considered preventable. A man who dies before his time, from a financial viewpoint, has reduced his family's and the Nation's wealth by the loss of his further productive years.

Retirement programs generally—State, Federal, and local government programs, as well as many private plans—stipulate 65 as the age of retirement. Any death that occurs before this age may be considered premature. If a man of 60 dies in 1948, for example, the assumption is that he might have lived and worked five more years and that his death is premature by that amount. The death of a man of 30 will constitute an annual loss to the Nation for the next 35 years he might normally have expected to live.

Thus, in figuring the losses for 1947 from premature death, the deaths below 65 that year are counted, and the life-years of those who died prematurely in previous years are added. On this basis, the total loss for 1947 was more than 27,000,000 life-years.

At present, 57 percent of all people are gainfully employed. On this basis, 15,000,000 of those lost life-years would represent lost production during 1947. Obviously, not all of the deaths came from injuries or diseases that science could prevent, but a close check on the causes of death indicates that, even with present knowledge, at least 20 percent of these lives could have been saved.

On this basis, it is a conservative estimate that, for 1947, the losses from premature deaths from preventable causes thus totaled $11,000,000,000 in lost production and wages.

GOVERNMENT EXPENDITURES FOR CIVILIAN HEALTH, 1947

	Federal	*State and local*	*Total*
Medical care of the needy (noninstitutional)	$25,000,000	$125,000,000	$150,000,000
Community health protection	69,000,000	247,000,000	316,000,000
Rehabilitation	18,000,000	7,000,000	25,000,000
Hospitals:			
Authorized construction	77,000,000	150,000,000	227,000,000
Maintenance of hospitals for tuberculous, mental, and chronic patients		373,000,000	373,000,000
Maintenance of general hospitals		300,000,000	300,000,000
Maintenance of Federal establishments, including veterans' medical care	534,000,000		534,000,000
Health manpower (training)	(*)	15,000,000	15,000,000
Research	20,000,000	2,000,000	22,000,000
Total	$743,000,000	$1,219,000,000	$1,962,000,000

*Less than $1,000,000.

These losses to the national wealth—totaling over $27,000,000,000—are cited here to indicate the magnitude of the problem that confronts the Nation. They provide the background against which we should consider all plans for governmental spending to improve civilian health.

What Do We Spend To Reduce This Loss?

Against these losses in production and wages—which last year amounted to more than 10 percent of our national total—the Nation as a whole spent—from public and private funds—a trifle more than 3 percent, or approximately $8,500,000,000, for medical and health services.

Of this, the local, State, and Federal Governments expended $1,962,000,000 for medical care and prevention, including the entire health program for veterans. Private individuals and organizations spent the rest—$6,500,000,000.

The table on the opposite page gives the details of the governmental expenditures for civilian health and for medical care during 1947.

From a purely financial angle, the conservation of our human resources is at least as profitable as conservation of our natural resources has proved to be in the past. The productive capacity of farm and city is enhanced through the harnessing of rivers to control floods and to produce power; through the control of soil erosion and consequent greater fertility of our crop lands; through the controlled utilization instead of the devastation of our forests. Such developments are commonplace investments. Most people recognize that the initial costs of these enterprises in the conservation of natural resources will be repaid many times over.

Investment in the greatest of all resources, the health of the people, will pay a similar dividend in increased productive and earning power—even if we leave out of account the relief of human suffering and the preservation of lives. Our annual losses of $27,000,000,000 from sickness and disability alone give us ample room for improvement.

To make a beginning on reducing these human and material losses due to bad health, I have proposed a gradual expansion of health services and resources. This

will involve, financially, an increase in spending by local, State, and Federal Governments, and the institution of a prepaid system of Government insurance.

AN ESTIMATE

The amount of additional governmental expenditure necessary is difficult to estimate with precision. The extent to which a system of national health insurance will reduce certain categories of direct governmental expenditure cannot be accurately calculated in advance. Certain government costs would be sharply cut.

Medical care for the needy outside of hospital and other institutions at present costs the Nation about $150,000,000 a year. Under the assumption that welfare agencies would pay premiums for the needy at the average per capita rate into the insurance fund, this total expenditure would probably be reduced by nearly 50 percent to $80,000,000, divided among Federal and State and local agencies.

ESTIMATED GOVERNMENT EXPENDITURES FOR CIVILIAN HEALTH, 1960*

	Federal	*State and local*	*Total*
General medical care for the needy	$40,000,000	$40,000,000	$80,000,000
Community health protection	570,000,000	680,000,000	1,250,000,000
Rehabilitation	70,000,000	30,000,000	100,000,000
Hospitals:			
Construction grant program	210,000,000	275,000,000	485,000,000
Maintenance of hospitals for tuberculous, mental, and chronic patients	335,000,000	695,000,000	1,030,000,000
Maintenance of general hospitals	25,000,000	30,000,000	55,000,000
Maintenance of Federal establishments, including veterans' medical care	900,000,000		900,000,000
Health manpower (training)	82,000,000	45,000,000	127,000,000
Research	80,000,000		80,000,000
TOTAL	$2,312,000,000	$1,795,000,000	$4,107,000,000

* Exclusive of Government health insurance.

It will be necessary, as recommended in chapter 3, in part to subsidize the maintenance costs of general hospitals in lower-income areas if we are to attain an equitable distribution of health facilities throughout the country. Most, if not all, of this subsidy could be eliminated eventually as hospital income rose from insurance payments for patients. Probably some subsidies—about $25,000,000 a year—would remain necessary in 1960, when insurance coverage may still be incomplete.

Other reductions in governmental expense would depend on the extent to which insurance funds help to support medical and other training schools and research. A great deal would depend on how much improvement in general health ultimately was accomplished through expanded health and medical resources and services, and the greater access to their help that would be afforded people through a prepaid system of Government health insurance.

The table on the opposite page shows what expenditures, exclusive of Federal contributions to Government health insurance, governments would be making for civilian health by 1960 under the program laid down in this report.

Government expenditures for civilian health on this basis would represent about 1.6 percent of a total personal income of $250,000,000,000—a reasonable expectation for 1960—and would still constitute a negligible proportion of the amount the Nation loses every year through ill health.

Where direct payments by private individuals and organizations for medical care are concerned, it is estimated that about two-thirds of the $6,500,000,000 now spent annually in this way would, in the future, be paid for by insurance premiums.

On What Programs Would Money Be Spent?

The increased governmental funds for civilian health would be spent on very much the same type of activity that currently is financed by various governments. The main categories are public health organization, research, training of personnel, maintenance of health facilities and construction of health facilities. It should be pointed out, in this connection, that many items are for expenditures that should be classed as capital investment—the building of hospitals and health centers, the building of water and sewerage

systems, financial aid for expansion of medical college facilities. To the considerable extent that these are nonrecurring expenditures, they are out of place in a recounting of annual costs. They are included because they would necessarily be financed by annual appropriations.

The various programs, and the expenditure involved, are briefly discussed in the following sections.

COMMUNITY PROGRAMS

This report has laid stress on the need for a well-rounded public health service in every community. In addition, there will be a need for further State-Federal expenditures for tuberculosis and venereal disease control, industrial hygiene, mental hygiene, maternal and child health, and crippled children programs; for new programs in the fields of dental care, diabetes, nutrition, heart disease, arthritis, rheumatism, accident prevention and medical care of migratory farm workers.

These items would increase the present grant programs for health to $840,000,000 a year. In addition, State-Federal financing should include $310,000,000 annually for grants and loans for the abatement of water pollution and $100,000,000 for special grants and loans for rural sanitation facilities.

HOSPITALS

Increased hospital construction and the recommended changes in the matching would indicate an annual Federal, State, and local outlay of $485,000,000 for hospital construction, of which the Federal share would be between $200,000,000 and $240,000,000.

Federal grants-in-aid to the States for the maintenance of general hospitals, tuberculosis and mental hospitals, and for the hospitalization of other chronic-disease patients should provide 40 percent of maintenance costs. A Government system of health insurance would eliminate most need for subsidies to general hospitals by 1960, but some will remain necessary. Health insurance will also absorb most of the present State and local expenditures for general hospital care. The remaining costs that may have to be carried by States and localities probably would not total more than $30,000,000—about 10 percent of the present $300,000,000 costs. If the hospital construction program is successful in expanding its facilities by 1960 to include 100,000 tuberculosis beds, 880,000

mental beds, and special assistance to help finance hospitalization of chronic patients, the outlay for maintenance of these types of hospitals by all governments in 1960 would amount to slightly more than $1,000,000,000.

OTHER PROGRAMS

It is hoped that enough research manpower will be available in 1960 to justify a Federal non-military outlay of $80,000,000 to $100,000,000. No estimate has been included for State appropriations for medical research, and expenditures by the armed services are not included.

The annual State-Federal outlay for training of medical manpower should approximate $135,000,000 by 1960, of which the Federal share would be $90,000,000. This would provide Federal assistance to schools of medicine, dentistry, nursing, and public health for defraying the cost of annual maintenance, estimated at $60,000,000. It would provide for construction outlays of $10,000,000 and grants of $12,000,000 worth of scholarships to 10 percent of the undergraduate student body and for graduate fellowships.

Realizing on Health Investment

Our analysis of the costs of the national health program laid down in the report shows that we may reasonably expect that an annual investment of $4,000,000,000 by State, local, and Federal Governments can ultimately produce an annual return—in national wealth—of several times that amount.

This is a good investment in terms of cash.

The returns to the Nation in terms of human welfare, of added national strength and vitality, are beyond dollar value.

Through this program we can expect to reduce deaths from preventable causes—those we have the knowledge and skills to prevent—by almost one-fourth in the next 10 years. We should be able to eliminate most deaths and sicknesses from malaria, typhoid, dysentery, undulant fever and typhus; from smallpox, diphtheria, whooping cough, tetanus, and measles.

We should be able to spread throughout most of the country the benefits of child and maternal health work and, by this means, sharply reduce the needless deaths of infants and mothers that occur each year by at least 45,000.

A concerted attack upon the problems of old age, and of chronic diseases, should at the very least delay the disability of tens of thousands of people, and reduce our national losses from these causes in terms of human lives, national productivity, and personal suffering. Rehabilitation will help many of those who are now dependent on others to lead independent and more active lives. We can place no top estimate on the things that can be achieved by future developments in the promotion of mental health as we overcome the severe shortages that now limit all progress in this field. All of these programs, with specific recommendations for their accomplishment, are spelled out in the chapters that follow.

It is enough to say here that, through wholehearted cooperative effort in this national program, we can measurably improve our individual health, the welfare of our communities, and the strength, productive power, and security of the Nation.

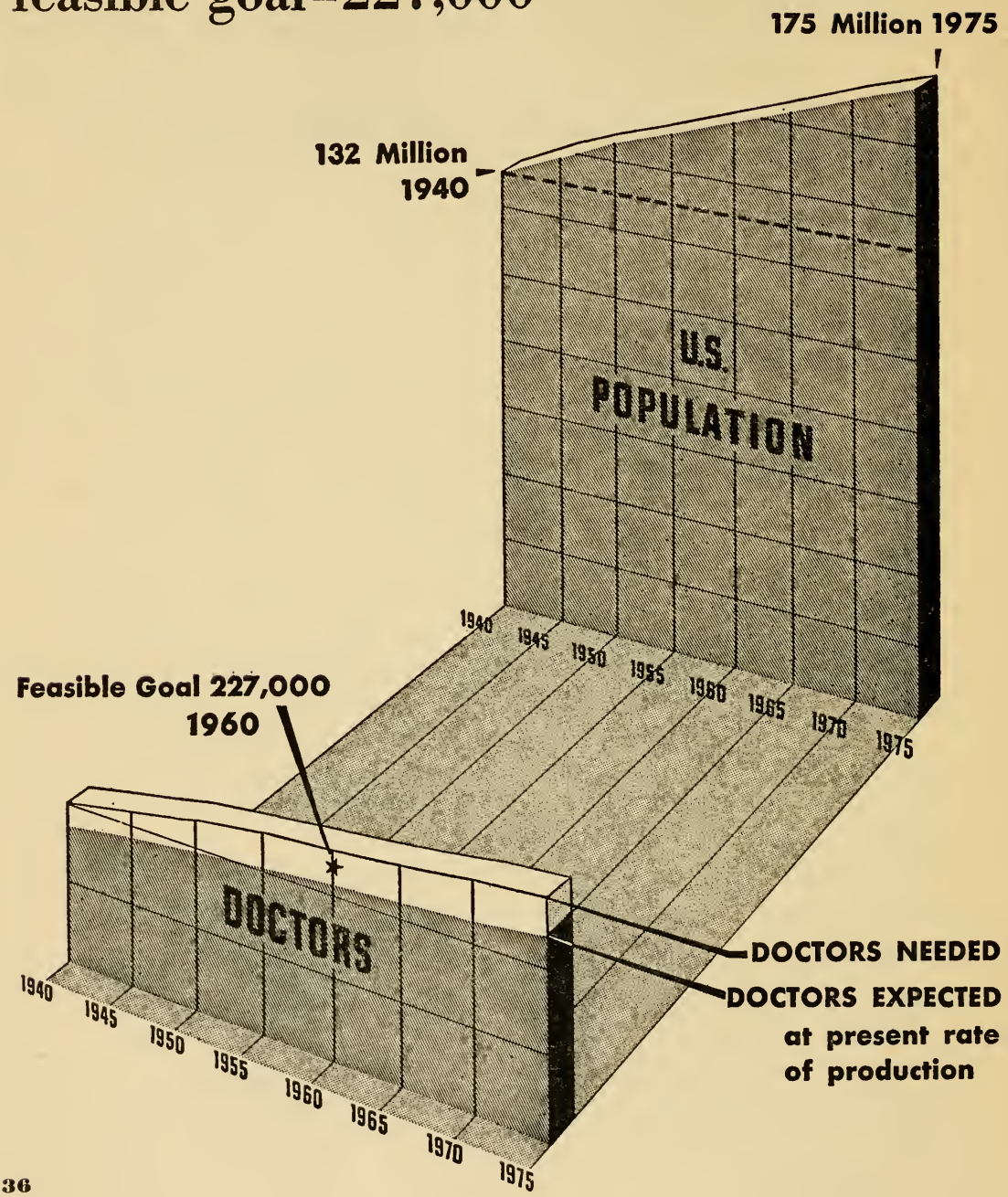
Our total goal, which is both for the individual and the Nation—since the welfare of the individual and the Nation are one and the

same thing in health—is clearly expressed in the statement of our aims for every American:

To assure for every individual his utmost degree of health—a condition in which all his physical and mental powers are functioning at their best—through providing complete health and medical services to everyone in the Nation; to do this for every man, woman, and child, without regard to his race or religion, the color of his skin, his place of national origin or the place he lives in our land, and without regard for his personal economic status.

WE NEED MORE DOCTORS

By 1960 we need 254,000; feasible goal–227,000



chapter 2

Enough Manpower Everywhere

First Health Goal

To increase our supplies of medical manpower until there is enough everywhere in the country to satisfy the health and medical needs of all the people; to do this by expanding and establishing medical colleges, training schools and teaching hospitals until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 percent.

The Nation has only about 80 percent as many physicians as it needs. Unless we take prompt and drastic action, we will still be in exactly that same position in 1960: We will have then only 80 percent as many physicians as our increased population will need.

In all categories of health and medical manpower, we face shortages of similar or greater magnitude. We need at least to triple our supply of psychiatrists and pediatricians. Our needs for medical teachers and research men are extreme.

Nor do such figures tell the full story of our deficiencies. Distribution of professional personnel is most uneven. In general, medical manpower moves, like the rest of the population, to the areas of greatest economic and social advantage. New York State, for example, has an average of one physician to every 500 persons; Mississippi, one to every 1,500. California has one dentist to every 1,300 people; South Carolina, one to every 5,000. Connecticut has one nurse for every 200 persons; Arkansas, one to 2,100. Hidden within these State averages are the records of some counties that have no resident physicians whatever.

The most obvious reason for the present shortage of medical manpower is that today more people are making more demands upon existing manpower. In part, this is because our national income stands at the highest level in history; more people have the funds to buy the medical services that they need.

Other factors that augment demand are: (1) Increasing complexity of medical care; (2) increasing health consciousness of the people; (3) increasing requirements of government services; and (4) increasing numbers of administrative, teaching, and research positions requiring physicians and other health personnel.

A realistic appraisal of manpower needs, however, must encompass much more than meeting the present effective demand. Instead of tailoring our supply down to the services that people can pay for, as we have in the past, we must rather assure the people the services required for all their medical needs.

MEASURING THE SHORTAGE

Forecasting the Nation's actual need for health manpower is complicated by many factors. Not the least of these is the potential need of the armed forces and the civilian population in the event of national emergency.

For normal times, however, an acceptable yardstick is provided by actual experience. It is an entirely realistic standard, based on levels of medical manpower already attained in our own country by the 12 States at the top of the ladder.

The 12-State yardstick for physicians—the average of the top quarter of our States—is one for every 667 persons. On this basis, applied throughout the Nation, we will need 254,000 physicians by 1960. Our present prospects are for only 212,000 by that date.

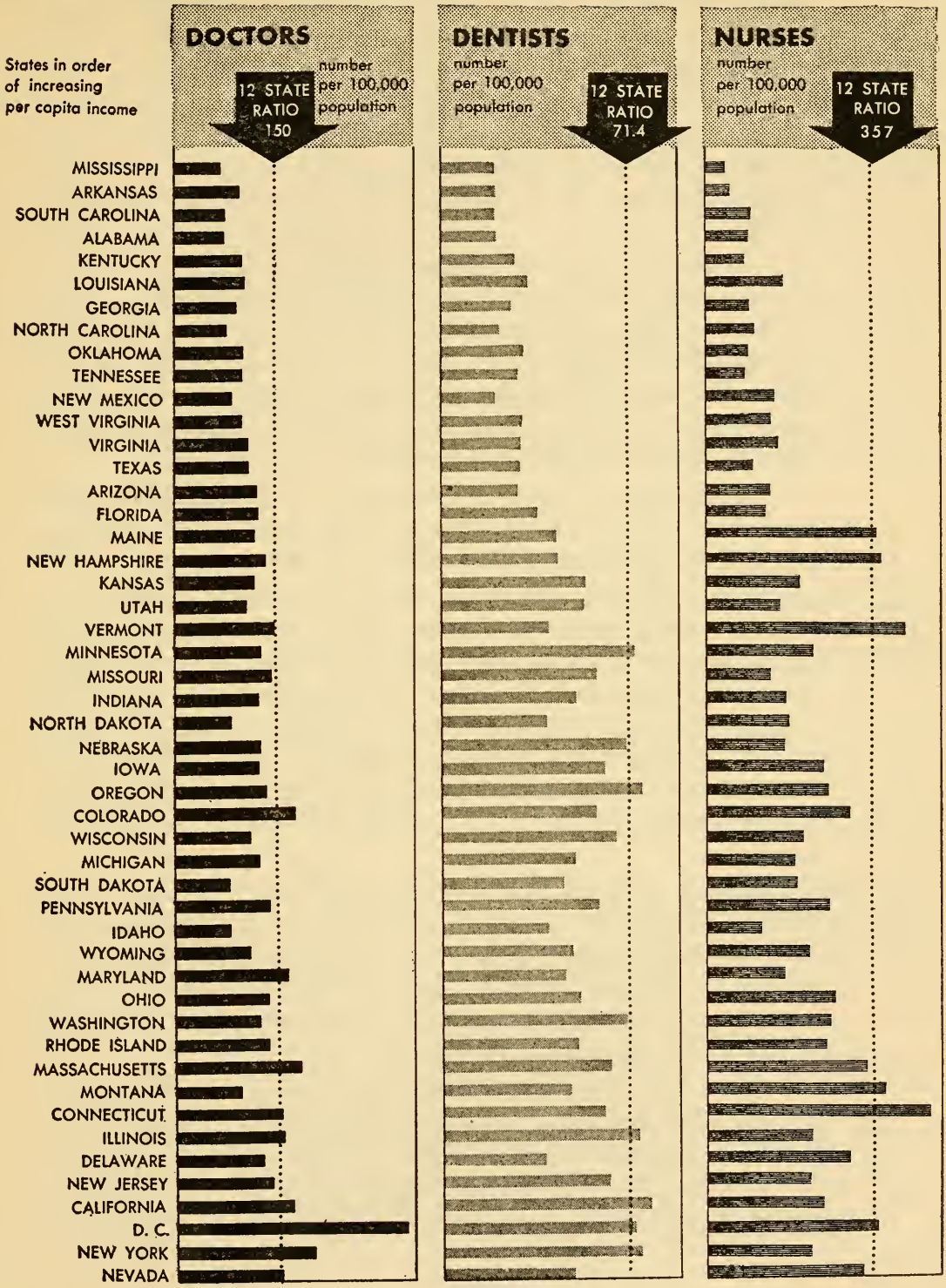
The 12-State yardstick for dentists is one dentist for every 1,400 persons. By this standard we will need 113,000 by 1960. Our prospects are for only 90,000.

The 12-State yardstick for nurses, both professional and practical, is one for every 280 persons. By this standard we will need 566,000 nurses by 1960. Our present prospects are for only 403,000. (See chart, State Targets for Manpower.)

PHYSICIANS

In terms of these standards of adequacy the supply of physicians today falls short of needs by nearly 20 percent. By 1960, at currently estimated rates of production, the Nation will be short 42,000 physicians. This total reflects shortages in all fields of medical care as well as in teaching and public health.

STATE TARGETS FOR MANPOWER



Two main factors which must be considered together will govern all our plans for the education of more medical manpower: one, the period of years needed for training; the other, the limited number of qualified colleges, schools, and training hospitals.

Even if complete training facilities could be greatly increased at once, a number of years would still be required to build an army of health workers adequate to the people's needs. A doctor, for example, requires from 7 to 10 years to complete his education; a nurse, 3 to 5 years.

At present, our production of physicians is limited by the fact that we have in the United States only 70 four-year medical schools, with an average enrollment of 335 students each. The average output is about 80 graduates per school for a national total of around 5,600. At current production rates, and taking into account six new schools now being organized, we can assume a maximum supply of only 212,000 active physicians by 1960.

Increasing our supply of physicians to the 254,000 actually needed by 1960 would require that we double the training capacity of our medical schools and do this, almost literally, overnight.

Even so, the schools would not begin to turn out double their current annual number of doctors until at least seven years from now. Moreover, building or expanding medical schools is not merely a matter of constructing facilities—and even that takes time—but more importantly, it is a question of long-term financing, and of assembling a competent teaching staff from a supply of scientists and doctors already strained by shortage. High quality must be assured; the production of a good doctor is not an assembly-line operation.

Special emphasis also must be placed on the provision of graduate education in order to develop the teaching personnel required to train larger numbers of medical students, the research personnel necessary for the continuing advancement of medical science and the specialists needed in other areas where deficiencies of personnel are particularly acute.

These factors make it obvious that we cannot quickly, nor indeed in a decade, double the capacity of our medical schools; we cannot raise our total supply of doctors to 254,000 by 1960. Even in our lifetime a shortage of such magnitude can be remedied only if we begin immediately, and continue unremittingly, to apply all

our resources, our energies, and our ingenuity to that accomplishment.

Negro Physicians

The relative lack of Negro physicians must be given special attention. Negroes comprise 10 percent of the total population but produce only 2 percent of the country's physicians.

We can no longer tolerate in our society a system of medical care under which Negro physicians and Negro patients are discriminated against.

There should be no racial barriers in the provision of adequate medical care. Qualified Negroes must be admitted without discrimination to the health professions, and to the use of training and health facilities. Their general educational opportunities also must be improved greatly so that more Negroes can qualify for the professions. The opportunity to study and practice medicine should be open to all eligible candidates regardless of race, creed, or sex.

Psychiatry

Experts in the medical specialties have repeatedly told us of their needs for psychiatrists. The statistics are alarming. For example, in 1947 the American Psychiatric Association reported only 4,500 certified psychiatrists—only about two-thirds in practice outside of institutions.

The immediate need estimated by the Mental Hygiene Section of the National Health Assembly is for at least 15,000. Some are urgently needed for institutional work; many more for mental health clinics. For example, 25 States now have no child guidance clinic in any community.

Distribution is another major problem. The limited supply of psychiatrists is concentrated in metropolitan areas—seldom in any community of fewer than 50,000 persons—yet it is in smaller communities that a majority of all people live.

Pediatrics

We have only about 3,500 pediatricians. We need at least three times that figure.

Distribution, moreover, is very uneven. In 1941, for example, only 4 percent of all certified pediatricians were practicing in towns of less than 10,000 population, or in the rural areas, where 60 percent of all children live. In places of 500,000 or more—where only

14 percent of the children are found—38 percent of all pediatricians were concentrated.

Other Shortages In Medical Fields

The shortage of physicians is matched by even more severe shortages among other groups of professional personnel—dentists, nurses, public health workers, and supporting technicians and workers in several score different categories. In pharmacy the supply of teachers and researchers has reached a dangerously low level.

DENTISTS

The present anticipated deficiency in the number of dentists is even more pronounced than the shortage of physicians. At present our supply of dentists is not even keeping pace with our rising population. In 1940 the Nation had one dentist to every 1,870 persons; by 1950, at present expected training rates, the ratio will have receded to one to every 1,900.

Our first aim must be to increase the supply of dentists so that we do not continue to fall behind.

Maintaining the present supply-ratio will call for dental school enrollments that are more than 25 percent above even the peak years of 1941–47, when the average was 8,400.

Maintenance of the current ratio is only a first step. It is doubtful if we could ever hope to clear up the accumulated needs of the past, estimated to require 400,000 man-years of dental work. We can, however, put particular emphasis on preventive work for children, and in the next decade begin to close the gap between current annual needs and the dental manpower available for the task.

We should by 1960 have at least one dentist for each 1,650 persons.

The need for greater opportunities for Negroes in dentistry is proportionately even greater than in the field of medicine. In 1947 only 313 Negro students were training for dentistry, most of them in two dental schools. It is urgent that immediate action be taken to increase the number of qualified Negro applicants for admission to dental schools and to expand their opportunities for dental education.

Nurses are the largest single group of health workers in the Nation. The American Nurses Association has estimated the current shortages of nurses at 42,000. Many more thousands will be needed by 1960, not only for existing hospitals but to staff the many new hospitals and local health centers being built, and to help in applying the new knowledge in patient care and public health.

The increased demand for nurses is demonstrated by the report before the National Health Assembly that the number of graduate nurses employed by teaching hospitals has increased by 270 percent since 1945. The fact that one-third of all the counties in the United States reported not a single full-time public health nurse in 1947 is indicative of future needs in the field of public health nursing.

Nurse Education

Meeting these needs will require considerable expansion of nurse and teaching facilities and improved quality of training. The entire training system requires extensive revision.

Schools attached to small hospitals with limited educational and clinical facilities should combine with other schools, or should utilize their facilities to offer clinical experience in larger schools. Nurse training should be concentrated in colleges and large hospitals which should develop affiliations with other hospitals, special institutions, and with public health and other facilities in both rural and urban communities. A tour of duty in such outlying hospitals would give students an insight into the opportunities and undoubtedly would attract a sizable number of nurses to those localities. Such tours of duty also would help upgrade the quality of nursing services in rural hospitals and relieve small hospitals of the need to maintain full teaching staffs.

Use of student nurses as hospital labor should be discontinued, and a sound alternative system of financing nurse training, and for providing nursing service in hospitals, should be devised.

Training courses for highly trained professional nurses can be shortened considerably by reducing the time students are forced to spend in the repetitive performance of routine duties. This points

to the training of supporting workers—particularly practical nurses. Through their use, efficient high-quality nursing care could be provided more economically.

PUBLIC HEALTH WORKERS

At least 60,000 well-trained local public health workers are needed immediately. The Nation has only 36,000, and two-thirds of these, by present standards, are inadequately trained.

This shortage is a major obstacle to necessary expansion of public health work. Present training facilities can supply only a fraction of the personnel needed—public health physicians, dentists, sanitary engineers, nurses, and others—not only for local health units but also for Federal, State, and voluntary organization work.

SUPPORTING PERSONNEL

All of the shortages among major categories of the medical professions are accentuated by equally sharp deficits among supporting personnel. The importance of these technicians and auxiliary workers cannot be overstressed. Their supporting services in laboratory and similar essential work can do much to enable physicians, dentists, and nurses to care for larger numbers of patients.

The extent of the shortages among such groups as physiotherapists, health educators, dental hygienists, psychiatric and medical social workers, and scores of others has never been estimated. We have, however, a few key figures:

Increase in hospital beds, even under the present limited Federal construction program, will require some 18,000 more technical personnel for hospitals.

Need for 50,000 physiotherapists for rehabilitation work was reported by the National Health Assembly.

Estimates on needs for psychiatric nurses run as high as 50,000; for psychiatric social workers, 14,000.

The Federal Security Agency is undertaking a continuing study to determine accurately the numbers of various supporting workers needed. In the meantime, we know that immediate steps must be taken to increase the supply.

Increasing Manpower —A Twofold Problem

Our approach to the problem of supplying our manpower needs must have the purpose not only of producing enough manpower but also of making sure that every area of the country has its equitable share.

Distribution is a many-faceted problem that involves the placing of hospitals and other facilities, possibly the location of new schools.

A Nation-wide system for prepayment health services on the insurance plan will help us meet these goals since medical manpower will be assured of payment for their services. Developments under a prepayment plan may also be expected to produce new economies in the use of manpower and, through organization, increase efficiency in the following three ways:

1. All health personnel, including new practitioners who now work virtually on a part-time basis, will find a full-time paying demand for their services;
2. Group practice, with its enormous savings in doctor and patient time, and its greater efficiency in diagnosis and treatment, will be encouraged; and
3. Wider use of supporting workers, more quickly trained than the top professional personnel, would be encouraged, with consequent savings in time throughout our health and medical services.

All of these factors will have their effect upon national requirements for physicians, dentists and other personnel and make it difficult to estimate accurately and precisely what our future needs will be.

It is not necessary to make precise estimates of our needs for physicians. Even attaining the 12-State standard for physicians and dentists by 1960 is beyond our resources.

Our first step then must be to set goals based on meeting the Nation's minimum demand and, beyond that, to push on toward achieving the 12-State standard of supply. The demand for 1960 will include, as an absolute minimum, staffing the expanded system of hospitals, local health units and health centers planned under the Hospital Survey and Construction Act of 1946; providing for the

increased needs of the armed services, veterans and other Federal services; and providing for basic minimum services throughout the Nation under an adequate system of prepayment for health services.

THE GOALS

It is within this realistic frame of reference that we set our feasible goals for 1960. They call for a sharp increase in our production rates for all classes of health and medical manpower.

Physicians

Increase our supply of physicians by 1960 to 227,000. While this total is less than the 254,000 needed, it will be a net gain of 15,000 over the number which would be produced by 1960 at the currently expected rate.

Such an increase will require that we progressively step up the output of our medical schools so that by 1960 we shall be producing 40 percent more physicians a year—8,000 instead of the present 5,600. This will not mean that we will have a net annual increase of 8,000 each year since about 4,000 doctors will leave service annually through retirement or death.

Dentists

Increase our supply of dentists by 1960 to 95,000. This will be a net gain of 5,000 over the number expected to be available in 1960 at presently anticipated rates of production.

Such an increase will require that we progressively step up the output of our dental schools so that by 1960 we will be producing 3,000 dentists a year—a 50-percent increase over the average for the last 10 years and a 20-percent increase over the most favorable estimates of future production.

Nurses

Increase our supply of nurses of all types, including trained nurses, to 443,000.

Such an increase will require that we progressively step up the output of nurses so that by 1960 we are producing more than 50 percent more nurses annually—47,500 instead of the currently expected 30,000.

Lack of Finances Cripples Schools

Attainment of these increases will require strong and immediate action to strengthen the medical and related training schools. The medical colleges, training schools, and teaching hospitals have a double task: They must expand rapidly and at the same time improve the quality of their instruction.

At the present time, many medical and health educational institutions are so crippled by lack of funds that they can do neither. Under the pressure of rising enrollments, many need financial assistance even to maintain present standards.

Within recent months the Association of American Medical Colleges underscored this situation when it pointed out that "the quality of medical education is in danger of deteriorating just when demands for medical care are unprecedented and steadily rising." It described the "under-financing of medical schools as a problem of national moment."

The National Health Assembly's Section on Professional Personnel asserted "the problem of maintaining the present supply and quality of physicians is definitely a problem of financing."

It is clear that the Nation must greatly increase its investment in education for all the health professions if we are to produce the manpower needed for health and medical services.

SOURCES

Traditionally, the medical, dental, nursing, and public health schools of this country receive support from four sources—private endowments, private gifts, tuition fees, and taxes. Well over half of the 70 four-year medical schools, for example, are maintained principally through endowments, gifts, and tuition fees. The remaining schools, primarily supported by state or city revenue, must also depend upon private sources for important parts of their income.

Endowments and gifts are failing as a source of revenue. Over the years, they have remained fixed or declined. At the same time, rapid advances in the health and medical sciences have added tremendously to the cost of professional education.

In 1910 the average medical school looked to tuition fees for about 70 percent of all its expenses. For the academic year 1947–48, budgets of the Nation's medical schools show that tuition made up

less than 28 percent of their total expenditures. The remaining 70 percent had to be made up elsewhere.

This shift has occurred in spite of the fact that tuition fees have risen so high that large numbers of qualified students are turning away from medicine because they cannot afford the cost.

While tuition fees in dental schools cover proportionately a greater part of training, the latest figures show that even here student fees total only 43 percent of the cost. Moreover, endowments in dentistry are almost negligible.

Similarly, the cost of training public health personnel is far beyond tuition fees.

While the cost of educating a nurse appears to be substantially below that of training other health personnel, most of the cost of nurse training is met by labor of the students in hospitals—a system that discourages candidates from entering the profession.

These conditions point to one inevitable conclusion: public funds are the only source of income sufficient to expand the professional schools to the degree necessary to meet our needs.

USE OF TAX FUNDS

State and Federal funds should be made available promptly for these purposes:

1. To assist schools now operating to maintain adequate standards of training.
2. To permit expansion of schools now operating so that they can accept more students.
3. To help organize additional schools, and to help those now being organized to get into operation at the first possible moment.
4. To provide scholarships and fellowships for qualified students without regard to race, creed, or sex.

Financial assistance should be available for salaries, equipment and construction. At the outset, the program will probably require at least $40,000,000 a year in Federal funds, in addition to all foreseeable contributions from State and private sources. As enrollments rise, Federal aid should be increased.

Expanding Schools

Rapid expansion of medical and training schools will inevitably create problems, but they are slight in comparison with the health

problems the Nation will face if it does not swiftly increase its production of health manpower. The schools, for example, must set up every safeguard to maintain and improve quality.

Actually, quality of instruction is already threatened in many schools, as has been pointed out, because of lack of funds. With the extra tax money that should be made available, maintenance of quality should not present an insuperable obstacle to expansion.

Probably not all schools, even with extra funds, will be able to increase their enrollments immediately. There is reason to believe, however, that many of our training institutions can take in additional students and that some can expand by as much as 10 percent.

A survey to make close estimates of potentialities for expansion would be valuable. A thorough study of our medical schools is planned by the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association. Several sections of the National Health Assembly urged that all haste be made with this survey. It will be eagerly awaited, but the urgency of the times will not permit delay. We must begin at once to expand the capacity of our medical and health schools.

New Schools

Six new medical schools are now being organized, and six more planned. These institutions must be transformed as rapidly as possible from blueprints into operating units.

In dentistry, public health, and the other health professions, a similar program is necessary. Existing dental schools in the United States must operate at a maximum capacity consistent with sound educational principles. Furthermore, the prompt establishment of additional dental schools in areas of demonstrated need as integral parts of qualified universities is essential.

Immediate attention also must be directed toward expansion of public health training facilities and to the establishment of new schools, where feasible, as rapidly as possible.

Scholarships

Expansion of facilities will not alone supply our manpower needs. The cost of professional education is beyond the financial capacity of a substantial proportion of qualified students. In order to make sure that the best students—not exclusively those who can afford the high tuitions—have the opportunity to train for medical and

health work, the Federal scholarships and fellowships as recommended by the President's Commission on Higher Education should be provided. The most important criterion for such scholarships must be an affirmative answer to the question, "Will this person make a good professional worker?"

There is real danger in the haphazard development of Federal scholarship programs. Competition for candidates, an unnecessarily early determination of career by students, could result in concentrations of better scholars in certain fields to the disadvantage of national welfare.

It is urgent, therefore, that integration of the various scholarship and fellowship programs be undertaken as quickly as possible.

Integration should be planned so as to focus administration for all scholarships for training, as well as fellowships for research, in a central authority.

Refresher Courses Of Key Importance

The vast complexity of modern medical science makes it impossible for a medical course alone to produce a finished physician. It can only provide the opportunity for basic knowledge, orientation and training in methods of scientific inquiry. Refresher, retraining and postgraduate studies are basic essentials to physicians in keeping abreast of rapid developments in the health sciences.

The medical profession is to be congratulated on the progress it has made in making available refresher and retraining study. It is likewise to be encouraged in its efforts to enroll increasing numbers of doctors in such courses. Neither the profession nor the public, however, can be content with refresher and graduate activities until more physicians throughout the country appreciate the need for keeping constantly apprised of the latest developments in medical science.

Although medical education really needs to be made a lifetime process for all physicians, most physicians do not take graduate work at regular intervals. Those in areas remote from medical research and training centers have particular difficulty in keeping pace with the many new discoveries.

The need to reduce the time lag between new medical discoveries and their widespread application is a challenge to all administrative, educational, and professional organizations in the field of

health. Many of the new techniques, such as caudal anesthesia, require fairly long periods of clinical instruction. Other discoveries, however, are simpler and could be more widely used if their value could be promptly and effectively demonstrated to physicians everywhere in the United States.

SCHOOLS' RESPONSIBILITY

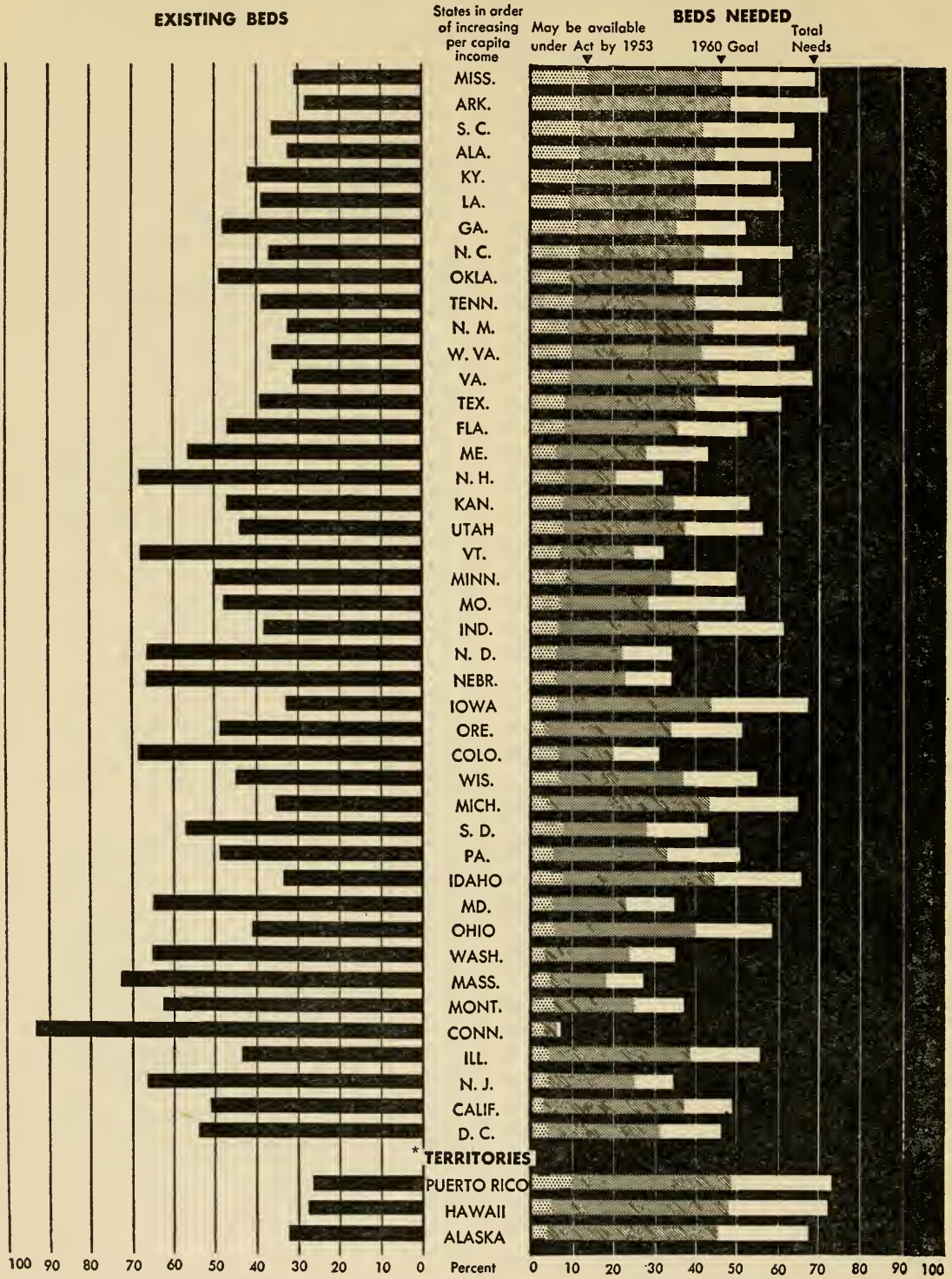
Medical schools should recognize a continuing responsibility for stimulating the interest of their graduates in recent medical developments and should devise methods of keeping their alumni well-informed on new diagnostic, preventive, and therapeutic agents and techniques. Public health departments, hospitals, voluntary health organizations, and medical societies should also cooperate in an effort to maintain a steady flow of technical information through all the various media for visual and auditory on-the-job training that can be developed or expanded.

An important step in this direction has already been taken by the Medical Film Institute of the Association of American Medical Colleges in plans which include distribution of motion pictures demonstrating the value and application of new medical discoveries. The possibilities of television in scientific and clinical training should be intensively explored. Wide distribution should be planned for clear and effectively written material describing new research developments that have been tested and found valuable in clinical application.

Immediate attention should also be given to aiding doctors to meet the costs of graduate education and to furthering the system of externships—providing temporary substitutes in practice—which is now gaining momentum with the development of the hospital facilities program.

The amount and the quality of graduate medical training available are limited by the capacity of the medical schools and the number of hospital positions open for resident physicians, as well as by geographic distances. The Federal Government should assist and stimulate the expansion of such training in medical schools and hospitals and the extension of refresher and postgraduate courses into areas where they will be easily accessible to all physicians. Medical organizations should be afforded financial assistance in offering periodic refresher and retraining work in their localities. Finally, States and communities should seriously review ways and means for requiring all physicians to take advantage of opportunities for graduate study.

OUR NEED FOR HOSPITAL BEDS



Surveys not yet submitted: ARIZONA, WYOMING, RHODE ISLAND, DELAWARE, NEW YORK, NEVADA

* Per capita income figures not available

chapter 3

Enough Hospitals Everywhere

Second Health Goal

To assure that there are enough hospitals beds of all kinds everywhere to meet the people's needs, and to finance hospitals so that they may give the highest quality services; to accomplish this by doubling the number of hospital beds, adding at least 600,000 by 1960; by building such auxiliary health and community centers as are needed, particularly in rural areas; and by uniting hospitals and centers into regional chains so that the most remote regions will have full access to modern and scientific medicine.

The Nation's hospitals are completely inadequate to meet the needs of all the people.

We have only about 900,000 acceptable hospital beds, outside of Federal hospitals, in the entire country, against established need for twice that number.

Large areas of the country—including 40 percent of all counties—have no acceptable general hospitals at all. Other areas are provided with facilities that meet only a fraction of the numerical need or that do not have the variety of service that may be necessary for individual patients. Moreover, millions of our people are unable to use the hospitals that exist in their communities either because they lack the money to pay for services, or because discrimination or segregation closes the doors against them.

Even when the Federal Government pays part of the construction costs, as it does under the Hospital Survey and Construction Act of 1946, many areas of the country cannot finance new hospitals either (1) because they cannot contribute enough toward construction, or (2) because even if hospitals were built, the local income levels are so low that sufficient income for hospital operation and maintenance cannot be guaranteed.

FIVE BASIC NEEDS

Our goals for our hospitals are implicit in the discussion of their deficiencies. Our program must be directed toward meeting demands under four general headings: quantity, distribution, integration, and quality.

Quantity

We have established, on the basis of experience, ratios of hospital beds to population which are considered adequate to meet the people's needs. There will be local variations in these ratios because of differences in composition of populations and local health problems. Our standards change as science progresses. But our first effort must be to apply these present ratios throughout the land.

Distribution

Certain geographical standards for distribution are necessary to assure reasonable access to everyone: ideally, a hospital within an hour's distance of any given home, and a rural community clinic with emergency beds located even more conveniently.

Integration

Basically, integration of hospital services means that there should be full cooperation among various hospitals in a given geographical area, thus linking all diagnostic and treatment facilities—from the rural or community clinic to the completely equipped modern medical center. In short, integration would afford all patients even in remote areas access to a quality and degree of care or services now generally available only in our larger well-to-do communities. Other advantages of such integration are discussed in more detail in chapter 9.

Quality

Our requirement for quality is that the highest possible standard must be achieved and maintained. Assuring, or even measuring hospital quality, is a difficult task. Good design and construction are basic, as are ample staffing with high-quality personnel and thorough equipping. Efficient administration and sound financing are fundamental. Integration into systems would offer positive benefits. Standards have been established, but their maintenance is a severe problem. In a very real sense, all that goes to make up a hospital contributes to the quality of care afforded.

Despite these faults in the total pattern, the Nation can well be proud of its hospitals. At its best, the American hospital and its standards of medical care are unsurpassed.

Compared with most other countries, the number of hospital beds in the United States in relation to total population is impressive. During 1946, more than one in every ten of our population—15,000,000 in all—was admitted to hospitals for treatment. But we are not concerned with comparisons. All needs must be met, and this is a matter of acknowledged national policy.

A COMPLEX PATTERN

Before consideration of the steps the Federal Government should take to assist in reaching our national goals, it is necessary to examine the pattern of our hospitals—their ownership, purposes, organization, and problems—in short, to look at what we have to work with.

We have 6,280 registered hospitals of all kinds in the United States. Including Federal hospitals and numbers of private and State institutions that do not come under the Hospital Construction Act, we have 1,500,000 beds.

There are sometimes systems of State mental hospitals; in a few cases, mostly centered around a medical college, small systems of general hospitals have been set up. But most hospitals are independent institutions that have no working or other connection with other hospitals. Their growth and development have been haphazard rather than according to plan.

Hospitals are divided by the specific diseases they treat, such as, for example, those for mental illness or for tuberculosis; by the kinds of patients they serve, such as veterans, merchant seamen, or, in the case of some city or county hospitals, only persons who are unable to pay for care in other institutions.

The general hospitals—those which provide most types of care, such as in surgery, general illness, and childbirth—have 44 percent of all beds. In terms of service rendered, these general hospitals care for 93 percent of all patients admitted to hospitals in any year.

More than three-fourths of the general hospital beds are operated on a nonprofit basis; the vast majority of them by voluntary associations or religious groups, sponsored and supported by private groups and public subscriptions for the benefit of the

community. It is among this group of general voluntary hospitals that the greatest difficulty occurs over financing the costs of operation and maintenance. This report deals chiefly with two groups of hospitals—those owned and operated by States or local governments and the nonprofit voluntary hospitals.

Three Key Problems Of Hospital Program

The three basic problems of meeting our hospital needs must be discussed together, since the solutions of all three are interdependent.

These are the three:

Quantity—Making sure there are enough beds;

Distribution—Making sure hospitals are everywhere they are needed; and

Finance—Making sure enough funds are provided so that hospital construction and hospital maintenance are guaranteed everywhere they are needed.

Quantity

Exclusive of federally owned institutions, the Nation must build hospitals providing more than 900,000 beds to meet the immediate needs of the people. State-by-State surveys, establishing this total, are based on standards set up by the States under the Hospital Construction Act. The basic standard prescribed that, for every thousand people in each State, there should be 4.5 beds in general hospitals, 2 beds for the chronically ill, 5 beds for mental patients, plus 2.5 beds for tuberculous patients for every average annual death from that disease. This averages about 13 beds of various kinds per thousand population.

The survey revealed the following hospital beds in existence and needed:

	Existing beds	*New beds needed*
General	467, 000	266, 000
Mental	429, 000	307, 000
Tuberculosis	84, 000	85, 000
Chronic	39, 000	246, 000
Total	1, 019, 000	904, 000

Some 150,000 of the existing beds are in hospitals whose facilities are obsolete or that for other reasons do not meet the standards under the Hospital Construction Act. Thus, our national total of acceptable beds is less than 900,000—about half our needs.

At an average estimated cost of $10,000 per hospital bed, the total cost of meeting our goal for hospitals is in the neighborhood of $9,000,000,000.

Distribution

Hospitals for the general public have followed purchasing power throughout the country. Where income levels are high and population dense, there frequently are more hospitals and more beds than provided for under the formulas of the present Hospital Construction Act. Where income levels are low, or where populations are scattered, there may be no hospitals at all. Distribution cannot be measured in simple numbers as can the deficit in hospital beds. Certain key facts, however, point up the problem.

1. Few of our States yet have enough general hospital beds to equal the standard set up for the Nation—4.5 per thousand; none has enough aceptable beds to meet the standard.

2. More than 40 percent of all counties in the United States, with a total population of over 15,000,000, have no acceptable general hospitals at all.

Not every county requires a hospital, but community hospitals of 50 beds and occasionally less should usually be placed in every community or area of 15,000 to 20,000 population.

In sparsely populated rural areas, public health and medical service centers—community clinics, as they are sometimes called—must be made available with some provision for bed patients. In general, a village of 500 persons that is 25 miles from a hospital probably should have such a bed-providing clinic; similarly a town of 3,000 within 5 or 6 miles of a hospital probably should also have a center and clinic, which would serve chiefly as an out-patient and diagnostic center.

Certain population groups also suffer in this pattern of unequal distribution. The great Negro populations of the South are, in general, very badly cared for; in the North, Negroes usually cannot obtain care except in publicly owned hospitals. Similar discriminations affect other racial and national minorities.

Finances

The problem of financing limits both the number of new hospitals or hospital additions to be built, and their location in areas of greatest need.

CONSTRUCTION

The Hospital Construction Act requires that communities, or States and communities together, must raise two dollars for each Federal dollar contributed for hospital construction.

In most States, legislation to provide State financial assistance has not yet been passed; these States make no contribution at all, and local communities must raise two-thirds of construction costs. At the other extreme, at least one State is preparing to contribute up to half of all needed funds, so that its lower-income districts need raise only 20 percent locally.

Hospital building at present is completely dependent upon State and local initiative in matching Federal funds. It is imperative that all States act vigorously to assure that even their most impoverished areas will be able to have the health facilities that they need.

MAINTENANCE

The burden of operation and maintenance costs is severe on all hospitals. Average costs in general hospitals rose 56 percent between 1939 and 1946—from $6.42 to $10 per patient per day. During 1947, costs increased another 18 to 20 percent. At present, annual maintenance costs of a given facility amount to about one-third of the total spent for construction and equipment.

It is not surprising that under these circumstances very few voluntary nonprofit hospitals receive enough from patients to meet their costs. Even under "normal" economic conditions the great majority require funds in addition to payments from patients. In 1946, this deficit amounted for all voluntary nonprofit general hospitals to 13 percent of total costs—almost $100,000,000.

In many hospitals these financial difficulties not only affect the quality of the care rendered, but they also limit efforts to meet the growing demands of the community which they serve.

Sources of Income

Hospital income is derived mainly from three sources: (1) Paying patients—either through direct payments or insurance payments;

(2) community funds—through gifts, legacies, bequests, endowments, Community Chest, and other fund-raising activities; and (3) tax funds—through Federal, State, or local reimbursement of costs of providing care.

Endowments and gifts have been sharply declining during the last decade. Income derived from voluntary insurance plans has not proved sufficient in every case to pay the actual costs of the services rendered to subscribers; moreover, the plans do not cover large proportions of the population. Nor are the sums paid by various governments—State, local, and Federal—sufficient to cover the costs of care to those for whom they have accepted responsibility.

The National Health Assembly's Section on Hospitals recommended that governments should undertake to meet the full costs of care for such patients. This would help but, at best, increased government payments of this kind would be an incomplete answer to the financial problems of hospitals.

Limit on Building

The problems inherent in financing hospital maintenance are serious barriers to privately sponsored construction, even where funds are available to build. They are an even greater obstacle to placing hospitals in the areas of greatest need under the Hospital Act. Even if a locality can raise its share of construction costs, an area of lower-income levels is completely unable to make reasonable guarantees, as required under the act, that maintenance income will be provided. Thus, the very purpose of the Hospital Construction Act is often defeated.

Meeting Our Needs

Under the Hospital Construction Act the Federal Government is contributing $75,000,000 a year to build hospitals. If fully expended and matched with $150,000,000 of local funds, this program will permit the Nation to build about one-eighth of its total needs by 1951.

At this rate of building, we will meet 1946's needs in 1986—40 years too late.

Private hospital construction cannot possibly fill the gap in our Federal building program.

For the 10 years before the war, private building was virtually at a standstill. During the war only emergency construction was

possible. In 1947, private construction reached an all-time peak of more than $100,000,000— less than a third of the Nation's current total of hospital construction. There is every reason to believe private building will slacken as war-delayed construction is completed. Hospital building programs are also slowed down by the natural reluctance of prudent members of hospital boards to proceed with planned construction for which funds are already in hand because increasing costs of operation raise the specter of uncontrollable deficits.

In view of all these factors, it must be accepted that:

1. The Federal Government must stimulate and assist in financing the major part of future hospital construction;
2. The Federal Government must underwrite and subsidize a significant portion of the maintenance costs of nonprofit hospitals of all kinds.

Federal subsidies can, of course, be sharply reduced or possibly eliminated in many cases when an adequate Nation-wide system of prepayment for health services is in operation. The economic base of our hospital system then would be firm enough to make maintenance subsidies unnecessary.

RECOMMENDATIONS

In order to provide for the hospital needs of our people within a reasonable period, the following recommendations are made:

1. The original intent of the Hospital Construction Act was to provide 20 to 25 percent of total hospital needs within a period of five years. Rising costs have cut the actual construction in half. Therefore, it is recommended:

That the minimum Congressional appropriations for hospital construction for the next two years should be at least $150,000,000 annually, which is double the present authorization of $75,000,000 a year, plus such additional funds as are necessary to increase the Federal share of construction costs in areas of greatest need.

2. Even the accelerated rate of building hospitals under such an increased appropriation would be totally inadequate to meet the needs of the people within a reasonable time. Therefore, it is recommended:

That as soon as possible, but certainly by the end of the first five years' operation of the amended Hospital

Construction Act, Federal funds should be increased so as to finance the addition of 600,000 beds to our hospitals by 1960 and 900,000 beds within 15 years.

3. Because lack of local funds prevents the building of many necessary hospitals, particularly in the areas of greatest need, the Federal percentage of contribution must be increased. Therefore, it is recommended:

That the Federal Government should provide up to 40 percent of construction costs, beginning in 1949, and should encourage States to provide another 40 percent to the end that impoverished areas will have to finance only 20 percent of original costs.

4. Since inability to make a guarantee of hospital income for maintenance and operation also is a major barrier to building hospitals in many areas of greatest need, no program will succeed in assuring adequate distribution of hospitals unless it deals with this issue. Therefore, it is recommended:

That the Federal Government, beginning in 1949, underwrite up to 40 percent of the maintenance cost of hospitals in selected areas of low per capita income for as long as such subsidies are needed.

5. Since discriminatory practices are a barrier equal to total absence of hospital facilities for many of our people, the present provisions of the Act which require equal facilities for all racial, religious, and national groups are indorsed. The Act, however, makes no stipulation concerning discriminatory practices which bar members of minority groups from serving on the staffs of hospitals. It is, therefore, recommended:

That all maintenance subsidies to hospitals be assured only on condition that professional personnel should be accepted as staff members, or as workers, in the underwritten hospitals without discrimination as to race, religion, or sex.

6. Since most States, particularly those receiving relatively small allotments under the Hospital Survey and Construction Act, are finding it difficult to organize an adequate State survey and construction staff with present State funds, it is recommended:

That Federal funds be made available to assist the States with administrative expenses under the Hospital Survey and Construction program.

CONCLUSIONS OF PLANNING COMMITTEE

Medical Care Section, National Health Assembly

1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental and social health should be available to all without regard to race, color, creed, residence, or economic status.

2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test."

3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional

a. services to persons or groups for whom special public responsibility is acknowledged and

b. services not available under prepayment or insurance.

4. Voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

5. The people have the right to establish voluntary insurance plans on a cooperative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

6. High standards of service, efficient administration and reasonable costs require:

a. Coordination of the services of physicians, hospitals, and other health agencies in all phases of prevention, diagnosis and treatment;

b. Effective cooperation between the providers and the consumers of such services.

7. A medical care program by itself will not solve the health problems of the Nation. It must be coordinated with all efforts directed toward providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental and social health of the people.

8. There are areas on which the Planning Committee is not yet prepared to report. In the meetings of the Medical Care Section, different views were expressed as to the method of effectuating the principle of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a national health insurance plan is necessary.

An Equal Chance for Health

Third Health Goal

To assure that every individual without regard to his economic status has full access to adequate medical services for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health.

The benefits of medical care are not equally available to all people. The health record of the country—one of the best in the world as judged by life expectancy and mortality rates—has been achieved in spite of the fact that millions of our people do not receive adequate health care.

Comparisons among various States and various income groups show clearly that great disparities exist in services available, and in people's access to them.

In New York State, for example, there are 4.8 general hospital beds per thousand population as compared with only 1.9 in Mississippi. This inequality in provision of hospital beds is reflected in the fact that New York residents received an average of 1.42 days of hospital care each in 1946, whereas people in Mississippi received less than a third as much—an average of 0.44 day's care each.

In the distribution of medical manpower, similar discrepancies exist. The latest available lists show that New York State had one physician for about every 500 persons, Mississippi, one to every 1,500; one dentist to every 1,300 persons in New York, compared to one to 5,200 in Mississippi; one nurse to every 450 persons in New York, compared to one for every 2,400 in Mississippi.*

It is significant in this connection that, by contrast with New York's per capita income in 1946 of more than $1,600, Mississippi's average was only $555. This is not an isolated case. A similar

*Public Health Bulletin No. 292, 1945; U. S. Bureau of the Census, Sixteenth Census of the United States—1940, Population, Vol. 3, The Labor Force (1943); Facts About Nursing, 1946, American Nurses' Association.

parallel between State income levels and supplies of services and resources can be traced, in the main, throughout the country.

Another indication of inequalities of care afforded people in various areas can be found in the statistics on services in childbirth. They show that here again the States with better levels of income generally have a much better record.

In Massachusetts, 97.2 percent of all births occur in hospitals, and virtually all the rest are at least attended by a physician. The per capita income level in Massachusetts was above $1,300 for 1946 when this record was made.

In South Carolina, the per capita income level that year was $729. South Carolina's record: 49.7 percent of births in hospitals; 20.8 percent attended by a doctor outside a hospital; 29.5 percent attended only by a midwife or other unspecified person.

The death rates, per thousand live births:

Massachusetts:	Maternal deaths, 1.3.
	Infant mortality, 31.6.
South Carolina:	Maternal deaths, 2.7.
	Infant mortality, 41.4.

The statistics quoted are, of course, selective, but a study of the table on the opposite page will show that they indicate a general trend. The table ranks the States according to per capita income, and shows that, for the most part, the well-to-do States have relatively abundant hospital facilities, a higher amount of hospital care per person, larger numbers of medical manpower in proportion to population, a higher percentage of births occurring in hospitals, a lower maternal and infant mortality rate. As per capita income declines, the reverse is generally true.

The conclusion is inescapable that, as among States, there is a direct relationship between the comparative wealth of a given State and the health services available; that this, in turn, has a direct bearing on the health record of the State.

CONTRASTS IN INCOME GROUPS

Recent figures comparing the health needs and services of various income groups are not available. One yardstick we can apply here is the health, and care, of Negroes as contrasted with a similar group of whites. Discrimination in both health and education operates to make the situation of the Negroes worse. Neverthe-

less, since Negroes generally are at the bottom of the economic level in most communities, comparative statistics do have economic significance.

The death rate for Negroes in 1945 was almost 50 percent higher than for whites, when corrected for age distribution—13.6 per 1,000 for Negroes, 9.2 per 1,000 for whites. Life expectancy for Negroes at birth is 17 percent less than for whites. The same disparity exists in records of childbirth. In infant mortality, the national rate was, for whites, 31.8 deaths per 1,000 live births; for Negroes, 49.5.

HEALTH SERVICES AND RECORDS BY STATES

States in order of per capita income	Per capita income, 1946	General hospital beds per 1,000 population, 1946*	Days of hospital care per capita, 1946*	Number of persons per physician, 1940	Number of persons per dentist, 1940	Percent of births in hospitals, 1946	Infant deaths per 1,000 live births, 1946	Maternal deaths per 1,000 live births, 1946
Nevada	$1,703	4.8	1.27	660	2,004	96.1	39.6	1.8
New York	1,633	4.8	1.42	496	1,314	96.9	29.1	1.2
District of Columbia	1,569	5.4	1.52	296	1,337	94.9	41.2	1.7
California	1,531	3.6	1.02	580	1,268	97.1	30.7	1.2
New Jersey	1,494	3.9	1.05	716	1,547	95.4	28.5	1.3
Delaware	1,493	4.3	1.12	786	2,538	88.7	29.7	1.3
Illinois	1,486	3.9	1.13	648	1,323	93.2	30.4	1.4
Connecticut	1,465	3.9	1.13	658	1,575	98.9	27.8	.9
Montana	1,394	6.1	1.72	1,048	2,020	96.6	34.8	1.4
Massachusetts	1,356	5.1	1.38	547	1,530	97.2	31.6	1.3
Rhode Island	1,347	4.0	1.15	742	1,892	95.2	29.5	1.4
Washington	1,346	3.9	1.11	790	1,376	98.2	33.4	1.1
Ohio	1,302	3.0	.85	741	1,831	89.6	31.3	1.3
Maryland	1,293	4.2	1.18	609	2,086	80.7	34.0	1.1
Wyoming	1,264	3.4	.82	915	2,022	93.0	33.1	1.6
Idaho	1,243	3.6	.89	1,241	2,441	96.5	32.9	1.6
Pennsylvania	1,238	4.1	1.16	732	1,664	88.1	33.0	1.5
South Dakota	1,228	4.0	1.18	1,266	2,122	90.0	29.6	1.0
Michigan	1,215	4.2	1.06	826	1,978	93.4	32.7	1.2
Wisconsin	1,198	3.9	1.13	891	1,484	94.0	30.0	1.4
Colorado	1,196	4.9	1.31	572	1,687	87.8	40.0	1.9
Oregon	1,188	3.3	.93	745	1,305	98.0	27.7	1.0
Iowa	1,183	3.0	.90	823	1,564	92.2	29.9	1.1
Nebraska	1,164	3.8	1.07	805	1,430	90.9	30.2	1.0
North Dakota	1,162	4.8	1.34	1,239	2,450	90.9	34.0	1.0
Indiana	1,158	2.8	.79	830	1,890	87.3	31.5	1.3
Missouri	1,143	3.5	1.02	714	1,651	78.2	33.0	1.6
Minnesota	1,090	4.5	1.34	792	1,344	95.2	28.6	.9
Vermont	1,085	3.8	1.09	687	2,363	88.5	34.0	1.4
Utah	1,063	3.6	.87	957	1,798	96.1	27.2	1.4
Kansas	1,062	3.4	.98	870	1,776	90.3	30.6	1.5
New Hampshire	1,048	4.5	1.16	749	2,194	96.5	31.4	1.3
Maine	1,044	3.3	.91	854	2,241	86.9	41.0	1.6
Florida	1,010	2.9	.71	834	2,646	73.4	39.4	3.0
Arizona	995	3.7	.86	841	3,242	85.3	41.5	2.1
Texas	954	2.5	.64	930	3,179	72.3	41.7	1.6
Virginia	952	2.9	.79	927	3,173	65.3	38.7	1.6
West Virginia	914	3.3	.88	1,037	3,186	54.4	40.9	1.5
New Mexico	911	2.6	.64	1,211	4,665	61.6	78.2	2.0
Tennessee	843	2.3	.64	1,003	3,455	60.7	38.5	1.8
Oklahoma	825	2.4	.60	993	3,140	77.7	32.5	1.6
North Carolina	817	2.7	.74	1,304	4,533	61.6	37.2	2.0
Georgia	809	2.5	.62	1,106	3,786	59.6	35.9	2.6
Louisiana	784	3.5	.85	959	3,000	71.2	37.2	2.0
Kentucky	778	2.3	.61	1,031	3,575	50.7	40.0	2.0
Alabama	733	2.2	.49	1,365	4,683	49.2	37.9	2.6
South Carolina	729	2.5	.65	1,355	5,263	49.7	41.4	2.7
Arkansas	697	1.8	.46	1,066	5,077	53.6	28.3	2.1
Mississippi	555	1.9	.44	1,459	5,212	38.6	37.5	3.1

*Federal hospitals excluded.

In South Carolina the mortality rate for white mothers was 1.3 per 1,000 live births, for Negro mothers it was 3.6 per 1,000 live births. This 170-percent higher mortality rate among Negro mothers can be related to the fact that a scant 14 percent of Negro births occurred in hospitals and 65.9 percent were attended merely by a midwife or other unspecified person. By contrast, only 2.5 percent of white births were in this latter class.

For income groups, without respect to race, there are no studies more recent than those of the Committee on the Costs of Medical Care in 1928–31, but their findings are no doubt still typical of the trend. The committee found, for example, that families with incomes of $1,200 or less a year received 1.9 physicians' home, office, or clinic calls per person a year, as against 4.7 such calls in families of $10,000 or more.

The contrasts in health services and health records among States with varying incomes, and among different income groups, make it clear that lack of individual and group purchasing power for needed medical care constitutes a major barrier against better health.

Why So Many People Lack Adequate Care

Many of the factors that deprive people of equal access to adequate care and services are detailed elsewhere in the report. In the main, they include the shortages of resources and facilities and inadequate coordination, locally, among organizations, institutions and personnel that supply health services. The fact that all these shortages, too, are heavily influenced by the economic factors will become apparent in the discussion.

From the financial standpoint, the chief barriers to adequate care and service include:

1. The increased cost of modern scientific medical care;
2. The irregular and unpredictable occurrence of sickness and of the costs of medical care, when bills are paid out of pocket by the individual on a fee-for-service basis; and
3. The low incomes of many individuals and low income levels of many communities.

HIGHER COST OF CARE

The modern physician or dentist is the product of long and expensive training that requires a large investment by him, and by the people who support medical and other schools through taxes or contributions. The physician's and dentist's services have to be supplemented by those of other well-trained professional workers—the nurse, laboratory and other technicians and various supporting personnel.

The general practitioner should be able to call freely on a variety of specialists if his patients are to receive adequate care. Physicians must also have at hand equipment and facilities for diagnosis and treatment, including the wonderful but very costly modern hospital.

These increased costs are reflected, for the patient, in larger fees charged by physicians, specialists, laboratories and hospitals, but they are a product of the advance of medical technique—the precise, involved and expert practices which make modern medicine the effective science that it is.

UNPREDICTABLE COSTS

The medical needs of the individual are in general irregular and unpredictable. No one can tell when sickness will strike. Costs are equally unpredictable when the individual has to meet charges out of pocket as they arise.

Averages indicate that, in a group of families of similar income levels, the majority will have no really serious or expensive illness in a given year and their medical costs will run below the average. At the other extreme, there will be a few who will have one or more serious illnesses that entail heavy medical expense. For those few, the medical bills incurred will amount to a large part of their total income.

A survey some years ago found that 10 percent of the families paid more than 40 percent of the total costs for the entire group. At the other extreme, 58 percent paid only 18 percent of the total group costs. The reasons become apparent when it is considered that a severe illness requiring, say, 30 days of hospital care with related doctors' and nurses' fees, can easily result in a bill of $1,000. Bills of $2,000 and $3,000 are by no means rare.

Chronic sickness may continue to cause severe financial drains year after year. If the wage earner is stricken, these heavy costs are accompanied by loss of income.

As long ago as 1939, the American Medical Association estimated that an income of $3,000 a year was not adequate to pay the costs of a major or chronic illness. Since then, the consumers' price index has risen approximately 75 percent. A family would need take-home pay of more than $5,000 to have the same spending power now that $3,000 gave in 1939. Nearly 80 percent of our families earn less than $5,000 and consequently would have difficulty meeting the costs of a serious or prolonged illness.

This becomes clear in the following tabulation, which brackets groups of the population according to family income as of 1946:

Percentage of Families in Various Income Brackets

Gross cash income	*Percentage of families*
$1,000 or less	12.8
$1,000 to $2,000	15.4
$2,000 to $3,000	19.5
$3,000 to $5,000	31.4
Over $5,000	20.9

These figures show that nearly 50 percent of the Nation's families—probably including about 70,000,000 of the population—had incomes below $3,000 in 1946. Average incomes have risen since then by about 10 percent, but the cost of living has increased even more. Most of these families have barely enough or not enough income to maintain a minimum American standard of adequate living. This is evident from a comparison of their incomes with the results of a Bureau of Labor Statistics study* of the budget needs of four-person families living in some 34 cities of the United States. The study found that their essential expenditures cost between $2,500 and $3,000 in 1946. By 1947, the costs of these essential purchases had risen to between $3,000 and $3,500. The expenses of a two-person family would be about two-thirds of this amount and, for all groups, would be somewhat lower in smaller towns or rural districts.

In the light of these facts, it is clear that close to 70,000,000 people will have difficulty in providing adequate minimal care for themselves and their families. The difficulty will, of course, be

*U. S. Bureau of Labor Statistics, City Worker's Family Budget, 34 cities of the United States, December 1947.

greatest for those at the bottom of the scale, least for those near $3,000. People with incomes above $3,000 will probably be able to purchase minimal care, and, as income rises, an increasing amount of the preventive and health-promotion services that are out of the question below that figure.

Why Lack of Wealth Means Lack of Health

The full results of this total situation cannot be shown without some consideration of the underlying economic structure of medical services. It is self-evident that there is no such thing as "free" service. Health care, like everything else, has to be paid for by someone. If the individual cannot pay, then to the extent that needed services are available to him, they are supplied by the community at large—the local, State or national community or all three together—by taxes, private or institutional philanthropy, or public subscription.

THE INDIVIDUAL

From the individual standpoint, and despite community help, services are available for the most part only to those who can buy them, and to the extent that they can buy them. Doctors do attend many people who cannot pay; hospitals conduct clinics and provide care financed by taxes or public subscription. Nevertheless, it is generally true that people who cannot pay for services go without them partly or entirely.

The payment of hospital and doctor bills threatens actual impoverishment to many families. Savings offer help to some, but the Federal Reserve Board, in 1947, found that 24 percent of all spending units—single persons or families—had no liquid assets at all, and that an additional 26 percent had less than $500. Great numbers of people thus have to borrow heavily to meet the costs of serious illness. Various studies of small loan business show that payment of doctor and hospital bills is the chief reason why people take out these high interest loans.

The alternative to exhaustion of savings or heavy debts is charity care, which people can generally obtain to the extent that it is

available in their communities, by submitting themselves to the indignity of a means test and proving their inability to pay.

Faced with these alternatives, people tend to gamble with their health. Instead of going to a doctor for periodic examinations or getting medical attention when they first have a complaint, they tend to delay and hope that the pain or weakness will disappear of itself.

Effects of Delay

How serious this can be is apparent at once if we consider the wholesale menace of tuberculosis and cancer. Thirty percent of cancer is curable if caught in time, according to national estimates; a much higher percentage of tuberculosis, nearly 100 percent, is curable if detected in its very early stages. This is equally true of syphilis.

The disabling effects of many other chronic diseases can be stayed, or even prevented entirely, if caught in time; malnutrition and other weakening or debilitating conditions can be cured. Early examination is an absolute essential if we are to reduce maternal and infant mortality. A great many of the benefits of modern medicine, particularly preventive care, are lost to people who do not have prompt and ready access to needed services.

There can be no question that many deaths, much disability and illness, occur every year because fear of impoverishment delays medical care, or because lack of funds prevents people from getting the best possible care.

THE RESULTS

The individual's inability to pay for needed care has serious effects on the local community and on the State. As the state-by-state table shows, where the per capita income level is low there are fewer personnel, and fewer services are received. Within the States, the deficits are even more marked.

The health of the Nation as a whole suffers from these gross disparities of services available for communities and for individuals. Equitable distribution of services cannot be accomplished in the face of local deficiency of group income. No provision of services, short of charity, will help the individual if he lacks the personal buying power to take advantage of them.

Lack of group purchasing power also makes it extremely difficult to increase production of such basic resources as manpower and facilities. No matter how humanitarian their purpose, physicians, by and large, cannot respond merely to the need of the people. That need must be backed up by enough stable purchasing power to assure the doctor or other health worker an adequate income.

What is true of doctors is equally the case with medical colleges, training schools, and teaching hospitals. They must plan their expansion and their production of medical manpower with an eye first of all for the economic potential of the Nation, rather than for the health needs of the people—as long as those needs are not matched by adequate purchasing power.

Even this brief summary of the problems of health finance makes it clear that unless we overcome the barrier of inadequate individual, community, and national purchasing power, the Nation will continue to be seriously handicapped in its efforts toward better national health; substantial improvement will be virtually impossible.

Facing The Economic Problem

Lack of purchasing power for health involves, of course, our individual and national standard of living. There is a strong temptation to believe that the only solution of the problem lies in a bigger and better national income, better distributed throughout the population. The truth is that even this gradual accomplishment would not satisfy our national health needs.

The people in the lower half of the income scale would still not be able to buy what they needed. Communities with lower per capita incomes would still not be able to support professional personnel and health facilities adequate to the needs of the people. Millions of persons would continue to delay in obtaining medical care, or go without it, because of fear of its cost. Many families would still face the prospect of hopeless debt as a result of expensive illness, and would not receive the preventive care that would promote positive health. Lack of wealth would continue to set a limit on health.

The present methods of paying for medical care have served us well in achieving the present level of health, but the evidence cited in this report shows that substantial further improvement demands new methods. First steps toward a better system of payment have been taken already under voluntary health insurance plans. For millions of people, these systems have made it possible to purchase a larger share of their health needs. Undoubtedly, the success of voluntary insurance in its limited field, as well as the grave need revealed by a survey of national health deficits, led the National Health Assembly's Section on Medical Care to the following conclusion:

> The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test." (Full text on page 62.)

Prepayment insurance—contributory health insurance—provides a way to create group purchasing power for health that is relatively independent of individual standards of living. It permits the financial resources of the whole group covered by insurance to be

brought to bear on community and individual problems. It replaces the present unpredictable costs for the individual with predictable costs for the group. It brings to the support of health and medical services the financial resources of all who benefit from them.

Some form of regular and periodic prepayment, or insurance, is a practical method of guaranteeing that people will have access—without financial worry and without a means test—to the medical care they need. It is a method of guaranteeing that there will be a stable and adequate supply of money to help reduce the deficits of communities, to stimulate the production of medical manpower and facilities, and to provide the continuing financial support they must have.

A FAIRER METHOD

Insurance also is a much fairer way of meeting the costs of medical care. At present, by far the largest share of all medical costs is borne by the sick. This is the same situation as if only those people who had fires in their homes or business places contributed to the upkeep of the local fire department. The result would clearly be less fire protection and more fire losses in life and property. The result of the system wherein the sick pay the major portion of the costs of medical care is similar—inadequate health protection.

A portion of every hospital bill, for example, is a charge for "readiness-to-serve." Maintenance of the hospital must go on at a certain level regardless of the number of patients served on any particular day. In a small hospital—say, of 50 beds—this "readiness-to-serve" factor, as measured by average occupancy of beds, may total as much as 45 percent of the patient's charge per day. It is less in larger communities and larger hospitals where a larger percentage of beds is kept in service, but in any case, without insurance, those who have to be hospitalized pay most of this "readiness-to-serve" bill for the entire community. Taxes and public subscriptions help to pay these heavy stand-by charges, but the burden falls heavily on the ill patient and his family. In an average year, only about one-fifth to one-tenth of the families pay hospital bills.

It is more difficult to estimate the "readiness-to-serve" costs for doctors, but their expenses must similarly be adjusted to the number of patients they serve, and neither taxes nor public subscriptions assist them. Yet people who may not, for a time, need

medical care, have a vital interest in having doctors, as well as hospitals, standing by in the community to give service at need.

The net result under present conditions—ameliorated where hospital insurance is carried bya large proportion of the population—is not only that the financial burdens fall with undue weight on those who pay bills each year, but also that the financial support for personnel and facilities is often less than the community could afford.

Voluntary or Government Insurance

The National Health Assembly's Section on Medical Care was a thoroughly representative group, with delegates and spokesmen from many parts of the country: physicians from national professional organizations, from private clinics, from cooperative groups; public health workers were present, as were representatives of insurance groups, of labor organizations, farm cooperatives and farm associations; of nursing and dental professions, and women's organizations and civic clubs. Because of their wide diversity, as well as because they were leaders in many fields, their areas of agreement have weight. I believe they represent a cross section of American opinion, and I am gratified that they reached the unanimous conclusion that contributory insurance should be the basic method for meeting the costs of medical care.

Beyond this agreement, there was considerable discussion of voluntary insurance plans and the advantages they offered, as contrasted with the possibilities of a Government insurance plan. There was no unanimous conclusion here. Many, though not all, representatives of labor and other consumer groups were strong spokesmen for a Government plan. Many, but not all, representatives of medical groups believed that voluntary insurance was the only acceptable solution.

WEIGHING THE ISSUES

I have stated repeatedly that I am in favor of a Government plan of insurance as the best means of giving the greatest number of people access to adequate medical care. Nevertheless, even though predisposed to favor governmental insurance, I have reexamined this entire issue as objectively as possible.

In the following sections of this chapter, I wish to point out, as I see them, the advantages and disadvantages of the two major types of prepayment insurance under consideration—the voluntary plans as contrasted with a Government plan.

The Medical Care Section provided certain criteria, accepted unanimously by the group, for appraising the effectiveness of any

YARDSTICK FOR INSURANCE PLANS

Medical Care Section, National Health Assembly

Points to be measured in determining the effectiveness of prepayment plans in meeting the medical care needs of the people:

1. The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury.

2. The proportion a plan covers of the population of its area—local, State or national, as the case may be. (Cost in relation to ability to pay, restrictions on enrollment imposed by actuarial considerations, income level, age, conditions of employment, means of securing enrollment and collecting premiums.)

3. The degree to which a plan makes use of and encourages the development of a high quality of medical care for its subscribers. (Standards of personnel and facilities; organization of services; emphasis on prevention of disease, promotion of health, health education.)

4. The degree to which freedom and willingness to experiment with methods of payment and operation are encouraged in a plan.

5. The degree to which a plan succeeds in arranging amounts and methods of payment and conditions of participation that are satisfactory to physicians, hospitals, and others serving the plan's subscribers.

6. The extent to which efficiency and economy in the operation of a plan are achieved and encouraged by its basic policies and its administrative techniques.

7. The extent to which the individuals or board who carry the ultimate responsibility for a plan represent the interest of those entitled to service and those who are paying the cost, as well as of the physicians, hospitals, or others who are providing the services.

Principles for the Improvement of Voluntary Prepayment Plans

1. There should be the freest opportunity for full cooperation among the providers and consumers of service in the establishment and the administration of medical care plans, provided that full control of the practice of medicine in the program must remain with doctors.

2. The Medical Care Section strongly urges the importance of joint conferences at the earliest possible date among representatives of the American Medical Association and of groups representing the consumers of medical care and services to study the question of the establishment and administration of medical care plans.

given plan. (Full text on opposite page.) It is possible to take these up, point by point, and apply them to both major types of insurance. To a limited extent, this has been done.

THE DOMINANT STANDARD

One overriding standard must, I feel, make the final determination of what course the Nation should follow in this matter of providing insurance coverage for health. Our goal is to raise the national health to the highest possible level, and this achievement requires that we enable everyone to have ready access to adequate health and medical services. A serious lack—perhaps the basic lack of our entire health effort—is the absence of any method that would permit every individual to obtain the kind of services, and all the services, he needs, to promote better health; to obtain this kind of service without regard for the level of his personal income.

A satisfactory system of health insurance should provide:

1. That everyone should have ready access to adequate health and medical services.

2. That everyone should have the kind of services, and all the services, he needs to promote better health.

3. That everyone should be able to obtain these without regard for the level of his personal income.

Obviously, these criteria go far beyond the intent of any voluntary insurance plan. The objectives of such plans are confined, by and large, to making it easier for some people to meet some of the expenses of medical care, chiefly hospitalization.

The question arises at once whether it is fair to judge the voluntary plans in the light of our larger goal—a goal they never accepted as their own. From the standpoint of the insurance plans themselves, probably it is not fair. From the standpoint of the national interest, the comparison is inescapable. The goal is fixed, and individual as well as national interest demands its achievement. We must, therefore, ascertain whether the voluntary methods can supply the health needs of the people according to the criteria here laid down, or whether some other system must be evolved.

Voluntary Insurance And The National Need

Insurance plans of the voluntary type have been operating in health fields for 50 years or more and, during the last 18, have expanded enormously, especially through the group enrollment of employees in large and medium-sized industrial and commercial establishments. Health benefits are increasingly being included in collective bargaining agreements.

For their subscribers, voluntary plans have for the most part done an excellent job. They have given millions of people some insurance protection; they have assisted millions toward better health by helping them to meet hospital and doctor bills. They have provided many hospitals and doctors some assurance of income, and in this way have made possible more and better service than would otherwise have been possible. These are solid achievements.

In measuring their achievements against national need, answers to the following questions will be important:

1. What services does an insurance plan offer to the people it enrolls, how comprehensive are these services, and how close do they come to reasonable standards of adequacy?
2. How many people does an insurance plan protect and which groups of people does it reach?
3. What are the prospects, under each heading, for improvement in the future?

1. What Services?

Voluntary plans for health insurance offer many varied types of benefits, particularly for medical care. By far the greatest portion of all subscribers are insured for hospitalization benefits alone.

HOSPITALIZATION

Plans for hospital care cover most of the basic hospital services that will be required for their subscribers in those hospitals that are affiliated with the plan. An increasing number of these plans are not providing services, but instead give the subscriber a specified cash payment to apply against his bill.

Hospital plans, however, do carry limitations. The number of days of care afforded are stipulated, and certain types of diseases—mental, venereal, and tuberculous—are generally excluded, as are

certain types of care. Obstetrical cases are either not included in benefits, or premiums must have been paid for a specified time, frequently ten months, before the subscriber is covered.

From the standpoint of the subscriber, these are the most satisfactory of all the health insurance plans, but they fail to provide hospitalization for certain categories of expensive illnesses or services and are limited to a fixed number of days of care.

From this standpoint, they do not meet the criteria of providing fully adequate services for health.

MEDICAL CARE

A number of health insurance plans offering physicians' services as well as hospital care have been established by industries and by consumer groups. Insurance plans sponsored by medical societies and offering protection against the costs of physicians' services started their growth much later than hospital plans and, in general, are closely related to them.

These plans provide, in the main, for physicians' services in hospitals; many are further limited to surgical cases only. They are very helpful in such cases, but since only a small percentage of all sickness is cared for in hospitals, and about one-third of such cases are not surgical, a great deal of sickness does not come under these plans.

Doctors' services outside of hospitals are rarely offered; nor are dental, nursing, and laboratory service often available.

In general, plans for doctors' care are subject to the same limitations as hospital care. An even larger percentage provides only cash payments, not services. Some that provide service allow the doctor to charge an additional fee if the subscriber earns above a certain amount.

The sicknesses excluded are, in general, the same ones that are not covered under hospitalization benefits and the stipulations are similar. Individual policies sold by commercial companies have even greater limitations. Care for sickness or conditions that exist at the time of enrollment is generally excluded, or covered only after a certain number of premiums have been paid. Commercial group policies usually terminate when an individual leaves the job with which the insurance is connected.

These medical care plans have helped their subscribers in meeting sickness costs and have helped significantly to extend

available services to large groups of people. Many of the sick have been enabled to get an amount and kind of care that would otherwise not have been available to them.

From the standpoint of national health, these plans for medical care insurance make a good contribution. Nevertheless, the limitations on their benefits prevent them from offering more than emergency care in sickness. They rarely provide the type of comprehensive care that would prevent sickness and promote better health.

2. How Many People?

It is difficult to estimate how many people now have insurance protection against medical costs. There are many different kinds of voluntary insurance plans and policies. Some people have comprehensive protection; others have only very limited protection; still others have two or more kinds of policies.

About 25,000,000 people—17 percent of the population—have insurance for actual services in hospitals, usually only for a limited number of days. Under many of the plans, not all special services in hospitals are covered and the subscriber must pay extra for them.

About 20,000,000 more people have policies for cash reimbursement of certain hospital bills, leaving part of the costs and services uninsured.

Only about 3,500,000—less than 3 percent of the population—have anything approximating comprehensive insurance protection that includes hospitalization and also doctors' care in office, home and hospital. In most cases, even these policies do not include such necessary items as dentistry, home nursing, expensive drugs and such appliances as eyeglasses or hearing aids.

In addition to these 3,500,000, some 16,000,000 or 17,000,000 people—nearly all of them included among those covered by hospital insurance—have protection against part of the costs of some physicians' services, usually restricted to hospitalized cases. Of these, about 14,000,000 have protection only in surgical and obstetrical cases that go to hospitals, and nearly all receive only a credit against their bills, with the doctor free to make additional charges.

WHICH PEOPLE, WHERE?

In estimating the value of the voluntary insurance plans' coverage of the population from the standpoint of national interest,

it is important to determine which people have protection and where they live.

For comprehensive medical care the coverage is not great, since only 3,500,000 in the entire country have even an approximation of this type of protection. Enrollment for hospitalization plus surgical benefits has spread mainly among industrial and commercial employees.

For hospitalization alone, some areas show a very high percentage of participation. In Rhode Island, for example, some 67 percent of the population is enrolled; in Massachusetts, about 41 percent. But in many other States the coverage is very light.

About 60 percent of all Blue Cross hospital plan members live in six rich industrial States that contain about 36 percent of the total population of the United States. In the South and West, which have 43 percent of the population, Blue Cross can count only about 17 percent of its members. Its enrollment is predominantly among city people employed in commerce and industry. Less than 3 percent of the rural population are subscribers.

The heavy concentration of coverage under the voluntary insurance plans has the advantage, from the standpoint of subscribers, that it helps support adequate facilities for their care. From the standpoint of national need, the uneven spread of the coverage means that millions of people cannot take advantage of these insurance plans.

3. Can Plans Improve?

BENEFITS

The rapid growth of voluntary insurance plans, particularly hospitalization plans, gives promise that they will continue to expand in the future. It is difficult to tell just how much of the population they may ultimately protect; or to what degree benefits may be increased. However, certain factors would seem to set definite limits.

One factor that requires limitations on benefits is the flat-rate premium charged by nearly all voluntary insurance plans. Under voluntary insurance, all subscribers have to be charged alike for the same benefits—and benefits naturally must be limited to what subscribers can pay for. Probably no other basis is ultimately practicable for voluntary insurance organizations, so that benefits will continue to be limited to what can be covered by the premiums paid in by the group. Every effort to increase benefits must be balanced

against a corresponding increase in premium, and the effect that higher rates may have in reducing membership.

The battle to balance premiums with outgo has the further effect—necessary to the insurance companies, but not helpful from the standpoint of improved national health—that voluntary plans must seek to avoid enrolling "bad risks," such as people over a specified age, or those not gainfully employed.

Service or Cash

Only a small percentage of the people covered by medical care plans are actually provided with service benefits. Under such plans, the member receives the service itself and the physician giving the service is paid by the insurance plan on an agreed-upon scale, but the doctor may be permitted to make an additional charge.

Better than half the people who have hospitalization insurance are entitled to "service" benefits. However, a third or more of the subscribers of nonprofit plans, and all in commercial plans, are entitled only to cash credits against their bills. Specified amounts of money may be paid for each day of hospitalization or for certain other services, and a ceiling is usually placed on the total that will be paid regardless of the duration and cost of hospitalization.

Under this system, payments have typically been substantially less than actual bills. As hospital costs and charges advance, the insurance payments have fallen even further behind.

Obviously, only service benefits give real and adequate protection to the people and encourage use of benefits for better health; cash or indemnity payments give only partial and incomplete protection.

No definite conclusion can be reached concerning the amount of benefits that can be offered in the future by voluntary insurance plans. However, the financial factors will inevitably operate in one of two ways: either premiums will be held down and membership enlarged at the sacrifice of adequate benefits; or benefits will be increased and the resultant higher premiums will tend to decrease membership.

COVERAGE

The cost of insurance—the flat-rate premium—undoubtedly places a ceiling on the number of persons who may be enrolled ultimately in voluntary insurance plans.

Under present plans the charges for hospitalization and for physicians' services in hospitalized surgical and obstetrical cases range from about $48 to $72 a year for a family—varying with local costs and with benefits provided. The number who on an absolute scale could afford to pay these premiums is difficult to estimate. Obviously it is not possible to fix on a specific income level and designate this as the cut-off point—to say that all families above a given level can afford to pay the $48 to $72 for protection against the costs of limited hospitalization and surgical or obstetrical care; that all below this level cannot. However, it is possible to make some informed guesses.

Below $1,000

It is extremely unlikely that any family of two or more persons with an income below $1,000 will be able to pay an insurance premium of $48 to $72 a year. There may be some exceptions, but in view of the financial situation of many families with incomes of $2,500 to $3,000 or more as revealed in the survey quoted earlier (see page 68) the families in this lower income bracket—with incomes of $84 a month and less—can for the most part hardly be counted as self-supporting. Certainly very few, if any, of the 18,000,000 people probably included in these families, will be able to pay their own way for even limited medical care through flat-rate voluntary insurance premiums.

Between $1,000 and $2,000

Most of the 22,000,000 people in families with incomes between $1,000 and $2,000—but only those near the upper limits of this group—will be able, with hardship, to pay for some medical care. Many of those for whom doctors reduce charges, or to whom they submit only nominal bills, will fall in this group. A single person with this earning power could, if provident, pay for insurance; a family could rarely hope to. It should be pointed out, in this connection, that 70 percent of all farm families had gross cash incomes in 1945 of less than $2,000; and 42 percent less than $1,000. Although the rise in prices for agricultural products since that time has probably lowered these percentages somewhat, the relative "cash money" situation of these farm groups has remained virtually unchanged.

Between $2,000 and $3,000

Twenty-eight million people are in the group of families with an annual income of $2,000 to $3,000 a year. Families near the upper range of this income group could afford limited voluntary insurance; others in this income group could not. The insurance in question—hospitalization, plus surgeons' and obstetrical fees—does not cover the routine type of illness that affects every family to a greater or lesser degree. Doctors' home and office calls are not included. Obviously, care of the latter type will have first call on the family budget. The urgency of sickness would compel this.

Subscription to voluntary insurance, especially for a type of care that does not confront the average family oftener than once in five years—the national average—will tend to be postponed until more urgent needs, for food, shelter, clothing or for immediate sickness, have been met. This will be particularly true where the insurance plan under consideration meets only a portion of the costs by limited cash indemnities, instead of providing service.

Wage earners in this income group, and below, could hardly be expected to make the genuine financial sacrifice necessary to purchase limited insurance if they faced the possibility of charges over and above the coverage under the insurance plan.

Logic thus indicates that only the most provident in this wage group, or those with an unusual amount of family sickness—"bad risks" from the insurance company viewpoint—will invest in this type of insurance. A liberal estimate would be that not more than one in three in the group between $2,000 and $3,000 would, or could, pay such voluntary insurance fees.

Comprehensive Care

Insurance plans that offered more comprehensive benefits would be worth a greater sacrifice on the part of the subscriber—a plan, for instance, that in addition to hospitalization, surgical and obstetrical fees, included physicians' home and office calls, dental, nursing and laboratory services, and partly financed such appliances as eyeglasses and more expensive drugs, which frequently cost more than doctors' calls. Such a plan would, of course, be more costly.

On a national scale, such additional care represents about 65 percent of total private expenditures for medical care and services. If the rates for these additional benefits were similar to those charged for lesser coverage by the Blue Cross hospitalization and Blue Shield

doctors' services plans, the total premiums for a family would range between $130 and $200 a year.

The amount of money normally spent by a family for routine illness could be applied to premiums for such a comprehensive insurance plan, if it provided service and prohibited supplementary fees. Even so, the insurance would represent a heavy charge against the family budget. Only those families that earned more than $3,000 would be able genuinely to afford such insurance.

Conclusion

It is apparent that on a flat-rate basis, the voluntary insurance plans can never enroll any appreciable proportion of the 18,000,000 people in families with incomes below $1,000 even in the limited hospitalization and surgeons' fees type of plan. The additional 22,000,000 in families with between $1,000 and $2,000 are almost all in the same position. Probably 20,000,000 more in families with between $2,000 and $3,000 will remain outside the protection of the plans. If insurance benefits are broadened enough to provide reasonably adequate care, the premiums are even more out of reach for all this group and will be prohibitive to many who earn even more.

This examination of the facts makes it clear that, at a maximum, only about half the families in the United States can afford even a moderately comprehensive health insurance plan, on a voluntary basis. The net result, then, would be to leave without adequate protection the very groups—those with incomes below $3,000—whose plight the Nation needs most to remedy in order to raise the country's level of health.

DISTRIBUTION

The limitation that lack of income places on expansion of voluntary insurance plans becomes even clearer when the coverage is matched with the per capita income levels of the various States. The accompanying table reveals that the spread of hospitalization insurance plans, for example, generally follows the same distribution pattern as the supply of doctors, hospitals and other health services. Where income levels are low, voluntary insurance plans have few subscribers; where income levels are high, membership is also high.

A few statistics prove the point. Massachusetts, with a per capita income of over $1,300, has 41 percent coverage of population

HOSPITALIZATION INSURANCE AND INCOME LEVELS

States in order of population enrolled in Blue Cross plans	Percentage of population enrolled, Blue Cross, Jan. 1948	Average per capita income (1946)
Rhode Island	67. 4	$1, 347
Delaware	50. 4	1, 493
Massachusetts	41. 4	1, 356
District of Columbia	40. 0	1, 569
Colorado	39. 3	1, 196
Connecticut	35. 6	1, 465
Ohio	35. 3	1, 302
New York	33. 0	1, 633
Pennsylvania	30. 1	1, 238
Minnesota	29. 4	1, 090
Missouri	26. 3	1, 143
New Hampshire	[1] 26. 0	1, 048
Vermont	[1] 26. 0	1, 085
New Jersey	24. 9	1, 494
Maryland	24. 4	1, 293
Maine	23. 6	1, 044
Illinois	23. 0	1, 486
Wisconsin	20. 6	1, 198
Michigan	19. 3	1, 215
Montana	17. 0	1, 394
Utah	16. 6	1, 063
Iowa	[2] 15. 7	1, 183
South Dakota	[2] 15. 7	1, 228
Kansas	14. 9	1, 062
North Carolina	13. 8	817
Virginia	11. 2	952
North Dakota	11. 0	1, 162
Idaho	10. 9	1, 243
Arizona	10. 5	995
West Virginia	9. 6	914
Oklahoma	9. 2	825
Wyoming	9. 0	1, 264
Nebraska	7. 8	1, 164
Kentucky	7. 8	778
Tennessee	7. 7	843
Alabama	7. 7	733
Indiana	7. 6	1, 158
California	[3] 7. 6	1, 531
Nevada	[3] 7. 6	1, 703
Louisiana	6. 7	784
Florida	4. 7	1, 010
Oregon	4. 5	1, 188
Texas	4. 4	954
Washington	3. 9	1, 346
Georgia	2. 7	809
New Mexico	2. 2	911
South Carolina	1. 5	729
Mississippi	[4] 0	555
Arkansas	[5] 0	697
TOTAL UNITED STATES	19. 2	1, 200

(1) New Hampshire and Vermont served jointly by one plan which has enrolled 26 percent of the aggregate population of both States. (2) Part of Iowa and South Dakota are served jointly by one plan. (3) Part of California and Nevada are served jointly by one plan. (4) Plan just getting under way. (5) No plan.

by Blue Cross plans. South Carolina, with an income average of about $700, has only 1.5 percent of its population enrolled. Rhode Island, average income $1,347, has 67 percent enrolled; Tennessee, with $843, has 7.7 percent enrolled. (See table, Hospitalization Insurance and Income Levels by States on preceding page.)

Conclusion

Maldistribution of health and medical services is one of the worst situations that results from inequalities of group purchasing power for health. It is apparent that the Blue Cross plans are not supplying, in the lower-income areas, the extra purchasing power that is necessary to increase their supply of health services and resources appreciably. Among the lower-income States, where, from the standpoint of national interest the need is greatest, not a single State has a high enrollment in such plans.

Evaluating Voluntary Plans

As measured against the national need, the voluntary insurance plans show these deficiencies:

1. They offer benefits that are inadequate when measured against the standard of providing individuals with the kind and amount of care they need to promote the best health. Because benefits must be matched with flat-rate premiums, it is doubtful that they can broaden these benefits enough to provide the care essential to the highest level of national health. The prevalence of cash indemnities, as contrasted with service plans, means that large numbers of people receive only partial protection against costs of care.
2. They cover only a fraction of the population and, on the flat-rate basis of voluntary plans, they probably will never be able to cover more than half the total population.
3. They have the poorest coverage where the need is greatest—in areas where lower income levels limit the quantity and quality of health resources and services.

These findings must be weighed against our requirements for a system of contributory health insurance. The Nation's responsibility is clear:

It must help to bring health to those who cannot pay the full premiums, as well as those who can.

It must help to supply lower-income areas with better resources and services for health.

It must help to assure that all people have all the services that they require.

It must accomplish these things by mobilizing the group purchasing power of the people, and without excessive drains on the Federal treasury.

The national health, the national prosperity, the national security, cannot be assured with less. I could continue further this examination into whether it is possible to finance care for the large majority of the American people through voluntary insurance plans, but I am convinced that the conclusion would not be changed. These three factors—the inadequacy of benefits offered, of the number of people covered, of the distribution of coverage—outbalance all others. The weight of the evidence is clear:

The people who need health insurance most will not be able to get it under voluntary plans. I am forced to the conclusion that the voluntary insurance plans can never do the job that the national interest requires to be done.

A Way To Improve Health

All our efforts to raise the level of national health will be greatly handicapped until funds are available with which to pay for adequate medical care. Furthermore, voluntary insurance plans cannot do the job that has to be done.

Under these circumstances, we have only two alternatives:

1. We can plan a method of prepaid Government health insurance, that can be tailored to meet the Nation's needs, or
2. We can go ahead as we have in the past.

There are many earnest people in the country who sincerely urge the latter course. They point out that American health is equal to the best in the world; they feel that it is dangerous to make any basic change in the system that has produced this achievement.

The Brookings Institution, in a recent report,* has taken this position. Its report terms the proposal of Government health insurance a revolutionary plan. In effect, it concluded that American health is the best in the world; that it will gradually improve in the future as it has for the last 30 or 40 years; that the best thing to do is to let it alone and make no changes.

I cannot accept this thesis. We can improve the Nation's health markedly. What was good enough 30 or 40 years ago, no longer is adequate. The system of 30 or 40 years ago, the system of today, is the system under which millions of our people are unable to obtain adequate medical care or services, either because of their personal income status, or because they live in areas where general lack of money has resulted in serious deficits of medical and health services.

I submit—and this entire report underscores the point—that American health, however good, has serious deficiencies. Each year 325,000 deaths occur which we have the knowledge and skills to prevent. In the face of this stark fact, this Nation will be shirking its responsibilities if it fails to take all feasible steps to achieve all possible improvement in national health.

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*The Issue of Compulsory Health Insurance, by George W. Bachman and Lewis Meriam, Washington, D. C., May 1948.

Let me be the first to concede that any plan for Government health insurance will present difficulties, just as any large-scale plan does at the outset. In the sections that follow, the disadvantages as well as the advantages of such plans will be carefully assayed. Before we can weigh them intelligently and reach any final decision on the issue, it is well to sketch out the proposal for a Government prepayment plan of health insurance, to point out what it could and could not accomplish and how quickly, and to define some of the safeguards that should be set up around such a system.

A Government Insurance Program

The prime objective of any plan for prepaid Government insurance for medical services would be the improved health of the people. It would accomplish this objective in two ways:

1. By eliminating the financial barrier between any person and the services he needs to promote better health; and
2. By stimulating the development of more nearly adequate supplies of health resources and their equitable distribution throughout the country—doctors, nurses, hospitals, and other services—through the assurance that there will be a steady and effective demand for those health services.

The logical sequence of events for accomplishing these ends would fall in this pattern:

PHASE ONE

Federal legislation to settle the basic policies of a system of Government insurance and to decide important details; and to provide for a three-year "tooling-up" period before the date on which insurance benefits are made available.

PHASE TWO

The tooling-up period, during which procedures would be worked out cooperatively by professional groups, localities, States, and the Federal Government; agreements arrived at with individuals and groups providing medical services; and the machinery for actual operations set up.

PHASE THREE

Operations begin, services are provided up to the ceiling set by resources as they exist at the time.

PHASE FOUR

Expansion of services, as the accelerated increase and improved distribution of medical manpower and facilities lift the ceiling, until comprehensive services are available to everyone, everywhere in the country.

Phase One—Legislation

A Federal law setting up a system of Government insurance would have to settle a good many basic policies and a number of important details. The following 12 points indicate some of the major items for legislative action and include some discussion of the problems involved:

1. *Objectives*

The law itself should contain statements of the broad aims, objectives and responsibilities of the program. Those would furnish policy guides to the public, the providers of services, and the administrators.

2. *Coverage*

The law should determine who would make prepayments and who would receive benefits. The coverage should be as broad as practicable. The benefits should be available to all gainfully employed persons who are covered and to their dependents. There should also be provision of health services for noninsured groups for whom public responsibility already is acknowledged, through special premiums paid by public and private agencies on their behalf.

3. *Premiums*

The law should specify the size of insurance payments, the Government's share in the costs, and the dates when they become payable. It is fundamental that rates should be based on individual ability to pay—that is, be established as a percentage of earnings instead of as a flat rate irrespective of income.

4. *Benefits*

The law should specify and describe the benefits—services and supplies—which are to be available to the insured persons at the expense of the insurance system. The benefits should be as comprehensive as possible with only such limitations as may be unavoidable at the beginning. The administrative authorities should have power to extend services as rapidly as practicable. It should be clearly specified that the benefits are to be administered through Federal-State-local cooperation, with the major emphasis on administration at the State and local levels, so that the keynote is

decentralization and local participation. It should be equally clear that payment for services provided through physicians, dentists, nurses, laboratories and hospitals would be made at rates and by methods mutually agreeable to them and the insurance system. Removal of limitations and expansion of services should be geared to the increase of our resources, so that there would be orderly evolution in moving toward a broader system of benefits.

5. *Guarantees to Insured Persons*

The law should give explicit guarantees to insured persons and their dependents, including guarantees as to their rights to benefit solely by reason of their insurance; their right to make a free choice—individually or in association with other insured persons—of physician, dentist, hospital, etc., and to make a change in that choice; their right to have their personal records kept confidential, to be protected against discrimination, to make complaints or appeals before appropriately constituted committees, and to have recourse to court review of administrative decisions which they believe are unfair. With such guarantees, insured persons would know that they would get what they are entitled to receive from the insurance system, and that the doctor-patient relationship would be maintained.

6. *Professional Freedoms*

The law should give equally explicit guarantees to the members of the professions who provide services, including the right to participate in the plan or not, to act individually or in groups, to accept or reject patients who choose them, to retain control of professional aspects of professional service, to choose the method of payment for services rendered, to negotiate rates or amounts of payment and other matters through representatives of their own choosing, to make complaints or appeals before appropriately constituted committees, and to turn to the courts for review of administrative decisions. Such guarantees would preserve the essential freedoms of the professions and assure that they could not be "regimented" by administrative officers.

7. *Benefits for Rural People*

The law should make special provisions to meet the needs of rural areas and the urban centers which serve them. Wide latitude should be given the Federal, State, and local administrations to make spe-

cial arrangements to provide and support professional manpower and facilities in these areas. This is essential if modern health services are to be brought to those who live far away from the large cities and if patients are to be able to travel to distant medical centers when necessary.

8. *Education and Research*

The law should make special provisions to furnish financial aid for professional education and for research, if these are not adequately provided under other legislation. Support of professional education, postgraduate training, refresher courses and research could—and should—be provided from the beginning of the insurance program, so that progress would be constantly stimulated.

9. *State and Local Administration*

Since the benefits would be provided in local areas under State plans, the law should state the minimum conditions to be observed by States and localities in administering the benefits on a decentralized basis. This would meet the insurance obligations of the Federal Government and the rights of insured persons and the providers of service. The conditions should include legal authorization for a State agency, performance of a State-wide survey and development of a State plan, observance of requirements and guarantees in the Federal law, use of State and local advisory councils with broad civic, consumer, and professional representation, merit system administration, allocation of funds to localities on a fair basis, and delegation of substantial administrative authority to local areas as mapped out by the State plan.

10. *Allocation of Funds*

The law should clearly state the policies to be observed or the formulas to be used by the Federal administrative board and its advisory council in allocating the insurance funds to the States.

11. *Federal Administration*

Administration of the national aspects of the program should be assigned to a small board of full-time members that included both professional and nonprofessional members, constituted so as to coordinate this insurance system with other social security and public health programs. The law should also establish an advisory

council, with members representing the interested public, consumer and professional groups, and with responsibility to advise the Federal board on all important decisions made within the framework laid down by Congress.

12. *Collections*

Administration of the insurance plan, if linked with the existing system of national old-age and survivors insurance, could take advantage of existing machinery for collection of contributions, safekeeping of funds, record-keeping, determination of eligibility for benefits, and could use the field offices and other facilities and personnel of the social insurance system. By using and building on the efficient system already in operation, the need for new administrative personnel and costs could be held to a minimum.

Phase Two—Tooling-up

A three-year wait between enactment of legislation and the effective date of insurance benefits is essential to the program. The "tooling-up" period would be employed:

1. To increase medical resources—doctors and hospitals, for example—and to encourage their better distribution, so as to provide the maximum services possible, beginning with the effective date;
2. To set up administrative and operating machinery and aid in training personnel nationally, in States, and locally;
3. To make certain that insured persons and providers of services know their rights and are ready to exercise them.

ADMINISTRATION

A first step in the tooling-up period would be establishment of the national administrative board. Directly afterward, consultations with State agencies could begin, and each State would be able to take the necessary steps to establish legal authority to participate in the program. It then could set up the nucleus of a State administrative agency, undertake surveys of resources and needs, consult with professional associations, formulate a State plan of operations, establish local administrative agencies, train personnel, start informing the public on rights under the law, and conduct other preparatory activities.

Contracts

After the administrative framework was set up, State and local agencies could negotiate contracts with the providers of service. Contracts would probably be a product of national as well as State-wide and local consultations with professional and public groups. Decisions would have to be reached on scope of services, rates and methods of payment to providers of services, working relations among general practitioners, specialists, hospitals, and laboratories, and related matters.

It is reasonable to assume that, during this preparatory period there will be a considerable increase in organization of services. Knowing in advance that on a given date there will be funds to pay for medical services, consumer groups and providers of service would have a new incentive to develop or organize local services which could operate within the framework of the State and national plan. Such local groups and organized services could contribute greatly to improving the quality and increasing the amount of care which can be furnished with available money, professional manpower and facilities.

These groups could also take an active part in the local recruitment of needed professional manpower and in the construction of needed hospitals and clinics. The operation of organized services could be of great value in preserving and increasing active local interest and participation in the work of the insurance system.

Insurance officers would make contracts variously with individual practitioners or hospitals, or with groups or combinations, and with established or newly developing voluntary organizations and associations.

Machinery

The preparations necessary for actual operation of the insurance system would depend on the exact form of the legislation. Near the end of the tooling-up stage, insurance cards would probably be prepared and issued to insured persons, showing their, and their dependents', eligibility for benefits.

If the initial health insurance coverage is the same as that under old-age and survivors insurance, no special collection of records will be needed for this purpose.

If health insurance coverage is broader, contributions during the preparatory period will determine the eligibility of individuals, as

well as build up a contingency reserve fund. Initial contributions of one-half or 1 percent on the first $4,800 earned in a year, divided equally between employers and employees—or otherwise, as prescribed by legislation—would probably be adequate during the tooling-up period; later the rate would have to be increased.

EDUCATION

Even before insurance benefits become effective, it will be essential that both users and providers of services have full information on what the insurance plan offers. Subscribers and doctors, hospitals, nurses, and all other providers of medical services must know their privileges and rights. The providers of services must know how services will be paid for, and what the fees will be.

Extensive education will be necessary to accomplish this, and wide public activity by the professions, by civic and consumer groups and by local, State, and Federal Governments will be required.

This is one of the more important tasks of the preparatory period.

MANPOWER AND FACILITIES

One of the early goals of the insurance plan will be an improvement in the distribution of health facilities and personnel. Assurance of steady financial support in areas that previously have lacked the funds to attract personnel or to finance facilities should do much to improve conditions, particularly in rural areas.

The preparatory period will allow time to aid physicians, dentists, and nurses who want to go to rural or other areas where they are acutely needed. Funds should be made available promptly to serve as stipends and subsidies for practitioners who locate in rural or other areas of shortage.

The interval also will permit some increase in manpower and construction of some hospitals, clinics, health centers, and other facilities where they are lacking or inadequate, as programmed in chapters 2 and 3.

Phase Three—Operations

Beginning with the effective date, three years after enactment of legislation, insured persons and their dependents would obtain the health and medical services they need up to the capacity of the

personnel and facilities existing at that time and the limits of local availability. Strong efforts during the tooling-up period will assure more personnel and facilities in many areas than is possible today. There would, however, be less service in many places during these first years than will be available later when resources and services have been further increased.

NUMBER COVERED

The total number of persons covered in the United States by health insurance will depend on the terms of the basic legislation. If the law were enacted at once, and coverage made identical with that of the present old-age and survivors insurance system, benefits would be available to some 85,000,000 persons, counting insured workers and their dependents—a little more than 60 percent of the population.

When old-age and survivors insurance is expanded to cover groups not now included, a matching expansion of health insurance could cover between 120,000,000 and 130,000,000 people—nearly 90 percent of the population.

The ultimate goal is that every person—100 percent of the population—should be eligible for insurance benefits.

Rural

Coverage under our present social security system excludes farmers and agricultural workers. Nevertheless, every year some 1,800,000 persons in these groups acquire credits under the present law because they have worked during off-seasons in industries or businesses that come under the legal coverage. Numerous groups of public and private experts and farm organizations have recommended that farmers and agricultural workers be brought fully under old-age and survivors insurance. Several years of intensive study have resulted in adequate solutions for all the main administrative problems connected with their coverage.

We can, and we should, base our planning for health insurance on the premise that farmers and agricultural workers will be included under the coverage of health insurance.

Improvement of rural health is one of the major requirements for raising the levels of national health. Manpower and hospital programs both include special recommendations to build up the

health resources of all lower-income areas, with particular reference to rural districts. Health insurance that includes the farmers and agricultural workers will permit further constructive steps. A prepayment plan will help to attract and to keep doctors in rural areas. It will help to maintain hospitals and, through guaranteeing income, to build new ones where they are lacking. Voluntary groups of rural people can build their own clinics and hospitals, arrange for or employ their own doctors, and have the services paid for out of the health insurance fund.

Special provisions for rural areas would be a part of the insurance plan and each State and locality would be enabled to provide such services as ambulances, travel expenses for patients and for physicians, nurses, dentists, and other professional workers. The plan would make special financial arrangements for rural students to go to medical college or other professional health schools and would assist them in settling in areas that served rural people. Income subsidies and guarantees should be used where necessary to recruit and to maintain adequate personnel. Public health work should be closely coordinated with medical services, especially for mothers and children.

Prepayment of medical care costs through health insurance, helping to accomplish these needed improvements, would give the farm population a square deal in medical services for the first time in our Nation's history.

SERVICES AVAILABLE

Physicians

Health insurance should, from the beginning, make the services of general practitioners of medicine generally available to all the insured. The plan should cover all the services which a legally qualified physician engaged in the general or family practice of medicine gives to his patients at his office, in the patient's home, at the hospital or clinic, or elsewhere. It should include preventive, diagnostic, and therapeutic treatment and care, periodic physical examinations, and the prescribing of necessary drugs and appliances.

In metropolitan areas, all important specialists' services—including surgical and obstetrical services—probably would be available at the outset. Arrangements would be made for specialists and consultants whenever necessary—for example, for obstetrics, pediatrics, major surgery, heart disease, cancer, and diseases of the eye,

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ear, nose, and throat. In medium-sized and smaller towns and in rural areas, the insured would have access to some kinds of specialists close by, but would probably have to go to urban centers or depend on visiting experts for other highly specialized services.

It will take some relocation and stretching of manpower to accomplish this. Until the manpower shortage is met—probably for the program's first years—there will have to be some limitations on these services; but with improved distribution, there should be fewer limitations than now exist in the shortage areas.

Insured persons would choose their own general practitioner or family doctor, and services would be available to them on presentation of their insurance cards. Their physician would, at need, refer them to a specialist, call on a laboratory for service, arrange for hospital care, or prescribe medicines, eyeglasses, or other special appliances which are benefits, without charge to the patient—or, possibly, with only a partial charge for the prescribed commodities.

Hospitals

General hospital services would be available to most insured persons, though in the first years some local deficiencies probably will exist. Hospitals would continue to be owned and managed by their present governing bodies, with full autonomy.

There would have to be an extra charge if a private room were used, and since demand may exceed the capacity of hospitals until the building program is complete, some limitations on the number of days of care probably would be necessary. As more beds became available, the limits could be raised or removed.

Smaller hospitals would not be able to provide all kinds of specialized services, but widespread insurance should expedite the integration of hospital services (see chapter 9) and give patients access to the supplementary services of larger, more completely staffed and equipped hospitals.

Dental Care

The extreme shortage of dental personnel makes it difficult to estimate the degree of availability under insurance. In many communities it should be possible to provide preventive dental care

at least for children, and minimum continuing care for adults. More than this may be possible in some areas, somewhat less in others, until more dentists and dental assistants can be trained.

Home Nursing

Similarly, the availability of home-nursing care will be uneven among different areas and may have to be limited to serious cases until the number of nurses increases.

COSTS OF INSURANCE

For the basic services—physicians, hospitals, expensive prescribed medicines and appliances—the insurance contributions in the first years after the program goes into effect would need to be raised from the nominal rate of the tooling-up period to about 3 percent of annual earnings up to $4,800 a year, probably divided between subscriber and employer.

If the dental and home-nursing services start on a limited basis and develop gradually, it will be difficult to fix a contribution schedule that would not require several changes. The cost might amount to an additional 0.5 percent of annual earnings at first and rise to about 1 percent when these services became more adequate. The Federal Government might consider paying for these services out of general revenue.

Such financing would be sufficient to pay for the services needed by the insured population at rates fair to the practitioners and the institutions furnishing the services.

Not an Added Burden

These expenditures would represent new burdens on the economy or on the contributors only to a limited extent. They would be, for the most part, substitutes for expenditures already being made, without insurance, for the same kinds of services. Under insurance, however, the expenditures would be made out of earnings all the time, when people are well, working and earning—not merely when they are ill. They would be made by all the people who work and earn, and not merely by those who happen to be sick. They would be made in fixed and budgetable percentages of earnings, regardless of how often illness strikes, how severe it is, and how much care is needed or how expensive it is.

Phase Four—Expansion

With the beginning of operations under Government insurance, the effect of increased demand for services would make itself felt. In time, however, supplies of manpower and facilities could be expected to increase to meet the demand. The Nation would keep its health program flexible, and increase benefits as rapidly as local supply situations permitted.

Total and per capita costs for the insurance system as a whole will increase as services expand, but even when comprehensive services are available to everyone in the country, the contribution rate should not rise more than an additional one percent—to a total of 4 percent. The Federal Government might use general revenues to supplement the contributions, as necessary, in the amounts equivalent to a fixed maximum percentage of contributions.

OBJECTIVES

From its inception, such a system of Government insurance as this would meet its first objective: It would greatly increase all the people's opportunity to use whatever services are available in their locality. From the first also, it would promote attainment of more comprehensive—especially more preventive—care than is possible by individual purchase on the present basis, and it would promote improved quality of care.

It would do both of these by encouraging increase in all kinds of health resources and in their use, and by stimulating also their more efficient organization—group practice, hospital systems, the increased community activity of hospitals and of medical colleges and training schools. Such organizations also would assist doctors in getting away from their practice long enough to take postgraduate and refresher courses, as well as vacations. Specialists would be enabled to work out of medical colleges in areas that now lack their service.

Prevention of Disease

Adequate health insurance is, by its very nature, a great assistance in preventive medicine. It places people in a position in which they can get medical care more promptly and more readily than otherwise. So long as many illnesses cannot be prevented, early access to professional attention, early diagnosis and all necessary care are the best means we have to check disease.

Concerted effort to encourage prevention of disease and development of "positive health" would become possible because lack of finances would no longer stand in the way. The closest possible coordination between the health insurance system and the public health agencies and programs, official and voluntary, is so important that it should be encouraged by explicit requirement of law.

EXPECTATIONS

One of the first effects of the insurance system would be an increase in the amount of recognized illness, an increase in the amount of service requested by the public, and some increase in expenditures for medical, hospital and other care. This would be the stage when health insurance brings unrecognized, hidden, or neglected illness out into the open by making medical care more easily available. We would begin catching up with our accumulated health needs and building up the use of preventive services.

After a few years of this, we should expect a leveling-off and eventually an actual decline in the amount of serious illness. The amount of service may continue on a high level, but the proportion of preventive services could be expected to increase.

Such an insurance plan will give valuable assistance in many aspects of health, as this discussion has shown, but it is not in itself a total national health program. Many other specific programs are necessary; they would both support, and be supported by, a system of Government health insurance. This emphasizes what I have said repeatedly—that health insurance is not an end in itself. It is, however, the best means that I can see for accomplishing certain definite objectives in health. An adequate plan, such as described here, for a thorough system of prepaid Government health insurance, would make five fundamental contributions to better health:

1. It would largely solve the individual's problem of paying for medical care, and thus help encourage prompt care and preventive treatment.

2. Because it creates a stable and assured financial basis for health services, it will generate effective demand and assure the fastest possible increase in our supply of medical manpower, health facilities and other essentials in all parts of the country.

3. Because insurance will pay for a patient's needs, doctors will be free to practice the highest quality of scientific medicine, uninhibited by the individual patient's ability to pay out of personal income for all the diagnostic and treatment services, hospitalization and nursing care which professional judgment prescribes.

4. Because insurance will abolish most of the financial obstacles to receiving medical care and help equalize community purchasing power, it will reduce the present large disparities in distribution of manpower and health facilities between lower-income areas and wealthier districts.

5. Because national health insurance will furnish a new and badly needed opportunity for coordination of all community and regional personnel and facilities, it will help build a more effective organization for providing the best in prevention, diagnosis and treatment.

Pros and Cons of The Plan

Six main arguments have been raised against a system of Government health insurance. To the extent that they are valid objections, they may be considered to constitute disadvantages of the plan.

Briefly, the six arguments are these: (1) That Government health insurance is socialized or state medicine, (2) that it is compulsory, (3) that it would be highly centralized and would concentrate too much power in Federal Government, (4) that there are not sufficient personnel and facilities to make it effective, (5) that it would cost too much, and (6) that it would open the way to over-use and other abuses and would lower the quality of medical services.

Let us consider these arguments, one by one.

ARGUMENT OF SOCIALIZATION

Little is gained by arguments that Government health insurance is or is not socialized medicine. This is a quarrel of definitions. Certainly, Government health insurance as proposed here is not socialized or state medicine. Basically, socialized or state medicine means that the Government owns and operates all hospitals, and that practicing physicians are employed by the Government on a salary basis. They, like firemen or policemen, are on Government pay rolls and come under full Government supervision.

Clearly, no such system is proposed under the plan for Government insurance laid down in this report.

Full freedom of choice should be left to doctors, hospitals, and all other instrumentalities of health as to whether they will participate. The method and rate of payment should be a matter for negotiation. Literally, the only change proposed by advocates of national health insurance is that, instead of the patient paying as he has money available, he would receive a service for which the doctor would be paid by the insurance system at a rate and by a method to which he had agreed. This is a thoroughly American system, resting upon insurance principles which have been part of our national fabric for generations.

Similar practices already exist in this country under voluntary plans. Likewise, today in this Nation, doctors are paid stipulated

fees for performing tasks of service to the public health, for example, in administering immunization treatments or in venereal disease therapy.

ARGUMENT OF COMPULSION

The compulsory quality of Government health insurance has been greatly exaggerated. The proposed plan is compulsory in only a single aspect—all persons in certain categories to be determined by their representatives in the Congress would pay a stipulated percentage of their income in exchange for services and benefits under a system of insurance. It would be compulsory in the same way that payments for unemployment insurance or old-age and survivors insurance are compulsory. The benefits of these systems are well established and they are an accepted and valuable part of our American way of living.

ARGUMENT OF CENTRALIZATION

It has been charged that, under a system of Government health insurance, all control would be lodged in the Federal Government, in one agency, or in the hands of one man. No such system is proposed in this report, and the intent is that actual administration of the program should rest mainly with the States and localities. The Federal Government's part would be to aid the State programs and to handle the finances of the total system, with a carefully designed system of checks and balances.

ADEQUACY OF RESOURCES

The statement has been made that Government health insurance could not be instituted because there are not sufficient personnel or facilities available to provide essential care. Two possible results are foreseen: One, that the Government would promise to supply care that could not be given because of shortage of personnel and facilities; two, that the increased patient load would reduce the standards of care.

This objection must be taken more seriously than others that have been raised. It is acknowledged that we do not now have enough personnel, enough hospitals and other resources and services to satisfy all the people's needs. This has long been recognized, and it is one important reason for the timetable approach to health in-

surance suggested in this report. The tooling-up period could do something to break the bottleneck of shortages, particularly in accomplishing better distribution of manpower and facilities. Concerted steps could be taken by rural or impoverished areas to provide facilities and attract personnel with the assurance that, on a given future date, insurance would provide a stable financial basis for medical and health services. This, and the data on resources in this report, makes it reasonably certain that there would be enough resources and services available, after the suggested tooling-up period, to give basic medical care benefits to millions who do not now have them.

The insurance system could not, of course, supply fully comprehensive services for everyone until there are enough physicians, dentists, nurses, hospitals and supporting personnel, and until these resources and facilities are more evenly distributed throughout the country; until there is a proper organization and coordination of services everywhere.

Because of this fact, it has been argued that a health insurance program should not be instituted until it can provide all necessary services to all people. The proposal, under this line of thinking, would be first to develop the resources and services and then to find a method for enabling people to have the purchasing power to buy them.

It is totally unrealistic to think of eliminating the deficits ahead of solving financial problems. It puts the cart before the horse. Facilities and manpower expand in response to effective demand, and demand depends on total group purchasing power. This principle of supply and demand operates throughout our economy.

It is acknowledged that there is a shortage of both personnel and facilities and that this constitutes a limitation on the amount of services that can be rendered at the outset. The plan as outlined here takes full account of this factor, and arranges to cut the pattern to fit the cloth. But it does more than this, and so far as I can determine it is the only plan which does so—it will provide the funds and generate the steady and increased demand which will assure us enough medical manpower and facilities in the foreseeable future.

ARGUMENT OF COST

The question of greater cost has been raised in two areas: One, that medical and health services would require a greater national expenditure under a system of Government health insurance; two, that administrative costs would be excessive.

The answer to the first part of this issue is simple and is supported by this entire report: The Nation needs to spend more for health. This is the only way in which national levels of health can be improved. But a large part of the expenditures under health insurance would not be added expenditures; money normally expended in direct payments for medical care during illness would be distributed by small payments over longer periods of time. All people under the plan would pay periodically and consequently the burden of sickness—ordinarily concentrated upon a small part of the population in any given year—would be spread over more time and over more people.

So far as administrative costs are concerned, there is no reason to believe that the total expenses would be as large in relation to premiums collected as in the nonprofit plans, where the expense runs to approximately 12 percent. Actually, administration by Government should prove less costly. An important part of the administrative cost incurred by voluntary plans is the expense of soliciting and retaining members—a situation that would not apply to the Government.

I can find no valid disadvantage to the plan on the question of cost.

QUALITY OF SERVICE

The most serious charge made against a system of Government health insurance is that it would inevitably lower the quality of medical service. It is asserted that, under such a program, (1) individuals would not have free choice of doctor; (2) that doctors would have to treat so many patients that they would not have time to give good and careful service; (3) that physicians would lose certain freedoms which they now have—such as the right to reject patients and to determine the fees to be charged; (4) that there would be abuses which would increase costs and lessen quality of care; (5) that the remuneration would be insufficient to give incentives to doctors to provide good service, that this weakens the doctor's interest in his patient, and destroys the important doctor-

patient relationship; and (6) that there would be political interference—all to the detriment of quality of service.

Because these are questions of extreme importance, I am going to discuss them in some detail, taking up the various points in order. It is important to emphasize, in this connection, that quality of service has two aspects—quality of service for the community or the Nation at large; and quality of service accorded the individual. National interest demands that both be improved.

It must also be mentioned that this and many of the other problems of a Government health insurance plan also exist in voluntary plans and have to be solved by these plans also.

Free Choice of Doctor

1. The charge that individuals would not have free choice of doctor.

THE NATION—Many people today do not have free choice of physician, for two reasons; (1) in many sections of the country, there are not enough doctors to meet the needs, and (2) many millions of people do not have the money to pay doctors.

Under these circumstances, it is ridiculous to discuss "freedom of choice" for these people. Those in areas that have few, if any physicians, those who cannot afford to pay a doctor, have equally no choice in the matter. In one case, they must "choose" the doctor that is available; in the other they must "choose" the doctor that charity provides.

A prepaid plan of Government health insurance would certainly provide greater freedom of choice for the millions of people included in both these categories because it would help assure a better supply of physicians in underprivileged areas, and because prepayment would entitle millions who cannot now pay to have the services of a doctor of their choice.

INDIVIDUALS—If legislation is drawn up in the terms suggested in this chapter, the individual would be guaranteed under the law the privilege of choosing the doctor he wishes, and of changing doctors if he should so desire, subject to the doctor's right to reject patients.

Doctor's Burden

2. The charge that doctors would have to treat so many patients that they would have no time to give good and careful service.

THE NATION—It is proposed that legislation provide that the amount of benefits available in any area of the country be limited to the resources—doctors, hospitals, and so on—that can be provided for that area during the "tooling-up" period. It is proposed, further, that benefits should be increased only as local resources are increased, with the proviso that all efforts be bent toward increasing both as rapidly as possible. This common-sense approach to the problem offers the best over-all guarantee that doctors will not be overburdened.

INDIVIDUALS—The suggested legislative provision is that the individual doctor have the right to reject or accept patients as he pleases, and on the same basis as now. This would certainly enable the individual doctor to limit his practice to the number of people he could care for. The individual patient, equally, would have the privilege of choosing any particular doctor or of changing doctors—he could change from a doctor who had too many patients. Difficulties for a popular doctor would undoubtedly arise as they do under the present system, but he would be under no greater compulsion than at present to care for all patients who come to him.

Doctor's Freedom

3. The charge that doctors would lose certain freedoms that they have now—such as the right to reject patients or to determine the fees to be charged.

The freedom to reject patients, as stated, would be reserved to doctors. As to fees, doctors would make an individual decision to participate in, or stay outside, the insurance plan. Those who wished to participate, and their representatives, would help make all decisions on rates of payment for services, as they have under voluntary plans in a number of the States. Flexibility of fees might be lost for the individual doctor who wished to participate, but this could operate to his advantage. Instead of charging one man $250 and another $25, according to the patient's individual ability to pay, the doctor would receive a uniform fee for a particular service. It is a fair assumption that, under a system of equal pay to the individual doctor for equal service, the total income of most doctors would be greater. Charity cases would be virtually eliminated.

Abuses of Services

4. The charge that "malingering" patients and some physicians would overuse services.

The experience of many voluntary health insurance plans in this country, and of compulsory plans in other countries, has shown that these abuses are greatly exaggerated and can be controlled either by organized action on the part of the physicians themselves, or by administrative procedures that have been tested by experience, or by a combination of both professional and administrative action.

Doctor's Incentives

5. The charge that the remuneration would be insufficient to give incentives to doctors to provide good services, that this weakens the doctor's interest in his patient and destroys the important doctor-patient relationship.

The clear implication of this assertion is that the doctor's chief interest in the patient is the fee that he collects for his services. Granted that doctors, like everyone else, have to be assured of their livelihood, I still cannot accept this purely financial interpretation of the intimate doctor-patient relationship. But, in any case as pointed out, most doctors could expect to earn better incomes under an insurance system than they do now. Large incomes are rare among doctors. Those few doctors whose incomes would not be increased under insurance probably would not participate. Reduction of income of the medical profession as a whole is, therefore, not an issue.

Granted an adequate income, the chief interest of any doctor is in practicing the best possible quality of scientific medicine, of providing the best care to his patients, and in having adequate facilities for his patient's needs. He will want to improve his skill and his knowledge by refresher courses and by contact with other leaders in medicine. Health insurance will help the doctor to do these things by assuring stability of income and by encouraging such coordination of services as would make possible a physician's release from practice in order to study.

If being paid by a third party, instead of the patient, would undermine the doctor-patient relationship and reduce the doctor's incentive, we might expect to find this situation at its worst where the doctor is paid on a salary basis, where he is not answerable to the patient but to his employer. In many of our best university medical schools and hospitals and in many of our most famous clinics, doctors are paid salaries by the institution—not fees by the patient. Yet those institutions are famous for quality of care, probably the best to be found anywhere in the world.

Political Issue

6. The charge that there would be political interference in the practice of medicine.

The system of Government health insurance which I suggest offers no opportunity for "politics," as I understand the term, to enter in. Political parties—Democrats, Republicans or whatnot—do not come into the picture. The role of the Federal Government would be to collect the insurance premiums, distribute the money among the States in accordance with a law passed by the Congress, and prescribe standards which State plans should meet. State Governments would adopt State-wide plans but would have little, if anything, to do with administration. Administration would be left in the hands of local boards composed of doctors and laymen. Neither doctors nor patients would have any contact with the Federal Government and only rarely with their State governments. The local administrative boards would not change with political upheavals. Under the Selective Service Act, local administrative boards were remarkably free from political influences. There is every reason to believe that local boards to administer health insurance would be equally free of "politics."

It is pure poppycock and deliberately misleading to say that Government health insurance would make medicine a "political football," that doctors would be victims of the spoils system, that they would be subject to orders of untrained lay clerks, that doctors could expect no advancement because of professional merit but only through political pull, etc., etc. Under the suggested law, professional men are guaranteed the fullest possible latitude and protection, and a system of administrative and judicial appeals would be set up.

It is clear to me, and it certainly is implicit in the pattern of legislation recommended herein, that the insurance system should be fully insulated from "politics" of all sorts, so that purely medical concerns are left in the hands of the physicians and there is no unwarranted interference or "political control of medicine."

WHAT CONSTITUTES QUALITY?

Many of the elements that make up high-quality medical care as it relates to doctors have become apparent in this discussion of a Government system of prepaid insurance. But high-quality care is

made up of more than the doctor-patient relationship, important though that is. Good medical care has been defined as "the application of all necessary services of modern scientific medicine to the needs of all the people."*

Fundamental to achieving this standard is the availability of adequate numbers of physicians and other professional personnel, of hospitals and other facilities for diagnosis and care. The quality of the training of medical personnel is critical. The changing and expanding science of medicine requires that patients have access to specialists in various fields of medicine and, at need, to special equipment and facilities.

As measured against these standards, this report has shown that very few of the people—probably only the well-to-do in large urban centers—have access to good medical care. The question arises of what health insurance, under the terms proposed, would do to make all necessary services of scientific medicine available to all the people.

The assistance that insurance would give in creating greater supplies of manpower, toward increasing facilities and toward achieving more equitable distribution of both throughout the country, has been explained. The advantages of coordinated services, particularly in providing modern medical care, are reviewed in chapter 9. The discussion shows clearly that both group practice and integration of hospital services—highly desirable developments—would be stimulated by health insurance. All of these results would assist in providing the elements of better medical care to more people.

In the light of all these facts, it is difficult to see how the plan given here for a Government system of prepaid insurance would lower the quality of medical care. It seems clear to me that the reverse is true; that for the Nation as a whole, it would work toward a vast improvement in quality. This is not to say that there will not be difficulties, but there are none that careful planning and fair-minded cooperation cannot overcome.

I am the more convinced of this because of the experience in some 34 States where voluntary insurance plans for medical care are in operation. In six of the States, 15 percent or more of the population is enrolled—in Delaware, 43 percent. In none of the States, so

*Fundamentals of Good Medical Care, by Roger I. Lee, M. D., and Lewis Webster Jones, January 1933.

far as I can ascertain, has any serious charge been made that those voluntary plans have lowered the quality of medical care.

Only one essential difference exists between the program as proposed here and the voluntary insurance plans of the various States: The voluntary insurance plans cover only a percentage of the population—in 27 such plans, less than 10 percent; the Government plan ultimately would cover everyone in every State.

While it is true that a bad health insurance system can certainly lower the quality of service, the program as set forth here has taken the fullest possible cognizance of these problems and is designed to prevent any lowering of quality, as well as to accomplish the aims that have been set forth.

SUMMARY

In conclusion, I recognize fully that Government health insurance is a highly controversial issue. The program as outlined here is not 100-percent perfect and is not a final answer to the health needs of the people. Some of the disadvantages of such a system present serious difficulties which, plan as we will, we cannot fully eliminate in advance. I am equally sure that, with good will and faith, and with energetic and continuing effort toward improvement, we can make Government health insurance workable and successful.

The compelling argument, however, that drives me to an advocacy of national health insurance is that I see no other possible way of bringing adequate medical service to fully half of the American people. It would, obviously, be nice if we could find some other way that would arouse less opposition from many members of the medical profession. But I see none. And seeing none, I am not willing to abandon my advocacy of a program that I believe will bring more adequate medical services to fully 70,000,000 people just because some members of the medical profession prefer to maintain the status quo. It seems to me impossible to argue fairly for the status quo in the face of the fact that there are more than 300,000 deaths each year that we have the knowledge and skills to prevent.

I, therefore, recommend that the President continue to urge upon the Congress the earliest possible enactment of government health insurance in some such terms as outlined in this report.

chapter 5

Mental Health

Fourth Health Goal

To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; to expand manpower and facilities for both preventive and curative work throughout the country; to accomplish these objectives through use of Federal research and other Federal assistance.

Mental instability is a costly, destructive force in the modern world. The toll in suffering, disability, and economic loss makes mental illness the leading health problem in the United States today. It incapacitates hundreds of thousands through disorders which are due to mental conflicts or through a combination of physical and mental factors.

The impact on the Nation can be measured by such figures as these:

Over half of all the patients in hospitals on any given day—some 600,000—are mental patients;

Every year, 150,000 are committed to mental hospitals;

2,000,000 men were either rejected or discharged by the armed services because of neuropsychiatric disorders.

From the standpoint of physical health alone, the full effects of mental disturbances have not yet been measured, but we already know some significant facts:

From 30 to 50 percent of all patients consulting doctors have complaints due at least in part to emotional disorders;

350,000 people each year are disabled from accidents; 60 percent of these accidents stem partly from personality causes and nearly one-third of these have no other cause.

In addition, there are serious social problems which often involve mental ill health. The losses in these related areas include:

1,700,000 crimes committed in the United States in 1946;

250,000 to 400,000 children under 18 years of age in our juvenile courts each year;

600,000 chronic alcoholics in the United States;

A ratio of one divorce granted to every three or four marriages performed.

All of these facts represent only those manifestations of mental illnesses that have become so acute they are a matter of public record. For every such case on the public records, there are scores more who have relatively minor emotional disturbances which may become much more serious.

It is estimated that 8,000,000 persons in the United States today are suffering from some mental disorder and that, throughout our population, one in every 20 persons will require psychiatric care at some time during his life. We may expect the incidence of mental illness to increase rather than diminish in the future, since older people are more prone to mental illness and the average age of our population is rising.

WEAPONS AGAINST MENTAL ILLNESS

The battle against mental disease is being fought with tragically inadequate weapons.

We have 4,500 psychiatrists—about one to every 32,000 population. We need at least 15,000, more than three times as many as we have.

We have only a fraction of the number of psychiatric nurses that we need.

Shortages of other categories of psychiatric workers are equally acute.

Of more than 600,000 hospital beds occupied by the mentally ill, only about 400,000 meet minimum standards; moreover, there is an immediate need for 307,000 more beds for mentally ill patients. Our mental hospitals are severely understaffed and underfinanced. We have 600 psychiatric clinics for preventive work, against an immediate need for 1,400. We have only a handful of child guidance clinics. We need one mental health clinic—providing among other things, child guidance services—for every 100,000 population.

We know practically nothing about the nature, cause, treatment, or prevention of many mental illnesses. For example, we have virtually no knowledge of the cause of schizophrenia, which afflicts nearly half of the hospitalized mental patients today.

The sums spent in research in mental illness are trifling—only about $1 for each estimated case of mental illness.

Mental Health—A Dynamic Concept

Mental health, like physical health, means more than the absence of disease. To give people the opportunity to achieve true mental and emotional fitness, the Nation must develop preventive programs in mental health. Valuable lessons were learned during the war about methods of diagnosis and treatment. These should be fully applied.

Many false ideas about mental illness are popularly accepted—including such myths as that mental illness is a disgrace and that mental illness is always inherited and incurable. These misconceptions need to be replaced with scientifically sound information: that mental illness is a disease which can be diagnosed, treated, and often cured; that the major preventive weapon in mental illness, as well as in physical illness, is early diagnosis and treatment.

The attack on the problem must be twofold, through individuals, and through environment. We must do our utmost to relieve people from the pressures of insecurity, discrimination, prejudice, and the other social and economic inequities that exist. We must simultaneously—working with children and with adults—attempt to help the individual attain that inner strength which will enable him to cope with his environment.

The Individual

The goal of the efforts for mental health is to help everyone toward the full release of all creative and productive powers for himself, for his community and Nation, and for a constructive and rewarding life. Mental health can be considered as attained when the individual has made an adjustment to the world, and to other people, which affords a maximum amount of effectiveness and happiness.

Mental health enables the individual to pursue reasonable, purposeful goals; to use his capacities and talents fruitfully; to possess a sense of security, of belonging, of being respected; to know that he is liked, or loved, and wanted; to have self-respect, self-reliance and a sense of achievement; to have the capacity for new experiences and new ideas. Mental health also means that an individual has learned to respect others, and to live with others, not only at home and in his own country, but in the world.

It is becoming increasingly recognized that the emotional components of physical illness are of major importance. Many emotional disorders are actually expressed as physical symptoms.

Types of diseases in which the emotional aspects have been proved to have great significance include: gastro-intestinal disorders, notably stomach ulcers; heart and circulatory illnesses, including high blood pressure; and arthritic diseases.

Illness is feeling as much as being. A child's feeling about a test in school can produce as severe a stomach ache as eating a spoiled custard. Other common psychosomatic disorders in children are spastic bowels, asthma, hypertension, and certain cardiac disorders.

Emotional factors are also of great importance in recovery from a majority of physical illnesses, and it is well known that psychological factors play a major role in overcoming physical disabilities, in convalescence, and in rehabilitation.

NATIONAL DEFENSE

Our medical experience in the recent war showed the toll taken by mental illness of our military manpower. Fifteen million men were examined in the draft and 1,500,000 were rejected for neuropsychiatric disorders—35 percent of the men rejected by the armed forces for all causes.

In spite of this initial screening, mental illness was the most frequent cause for medical discharge from the armed forces.

In all, the total amount of military manpower lost because of neuropsychiatric disorders was nearly 2,000,000 men. More than half of those hospitalized by the Veterans Administration are neuropsychiatric patients, and perhaps as much as a third of disability pensions is due to mental illness.

It is estimated that 1,000,000 children attending our public schools today will spend some part of their lives as patients in mental hospitals. The causal factors of this serious situation lie to a great extent in emotionally damaging experiences of infancy and childhood and in the circumstances surrounding children in their homes and in their community.

Many will become psychotic and will require hospitalization. A significant number will have neurotic symptoms so disrupting to family life that they cannot fit into the normal home. These include (1) the "acting out" child who has little or no restraint on his impulses and is destructive and aggressive; (2) children who have developed resistance to accepted standards of behavior and get into trouble with the law because they lie, steal, run away, get into sexual difficulties; (3) children who are suffering from compulsions, obsessions, phobias, and hysterical physical symptoms.

In addition to this large group of "problem children" millions of others conditioned by early damaging emotional experiences will become so hampered in their normal personality development that they will be unable to take their place successfully in the family, the community, or society as a whole. They will become the maladjusted adults of tomorrow.

It is of primary importance that our children have the opportunity to develop into emotionally healthy adults. The child must be born and reared in emotional security.

He must be helped, by degrees, to face the meaning of his own feelings and those of the people around him, in his family, his community, his nation, and in the world. He must be allowed to grow up free of taboos, anxieties, and superstitions.

He must be encouraged gradually to take his place in a democratic society as an imaginative and responsible citizen, concerned with the common good, and able "to live harmoniously in a total changing environment." This is our ultimate goal for every child.

The Environment

Man's mental as well as physical health is very much at the mercy of what goes on about him. The economic insecurity of unemployment and old age, the lack of opportunity for education

and adequate health services, poor housing and lack of good sanitation, prejudice and discrimination, failure to share in the civil liberties guaranteed all citizens, inflation, the threat of atomic war—these are very real everyday problems and they are the kind of social factors that can wear away personality defenses and destroy mental health.

Many organizations, both voluntary and official, are striving to build a more stable society and thereby enhance the security of the individual. The importance of such efforts in the total program for better mental health cannot be overemphasized.

The health, education, and security programs carried out within the Federal Security Agency, in addition to many programs of direct assistance, are, in varying degrees, giving millions of Americans security in certain vital areas and helping to relieve the anxieties so damaging to mental well-being. The Agency administers programs for old-age and survivors insurance, unemployment insurance, old-age assistance, education, a job-placement service, aid for the physically handicapped, and health services. It also provides special services for dependent and crippled children, for maternal and child health, and for child welfare.

The total impact of all these programs helps to relieve the stress and strain on millions of our citizens and to give them better opportunities for mental health.

Much more needs to be done, however. For example, the strains set up by discrimination against citizens of minority groups are severely damaging. In this connection, implementation of the recommendations contained in the report of the President's Committee on Civil Rights will go far to alleviate many present tensions.

What Must Be Done To Aid Mental Health?

To make maximum progress in mental health, the obstacles of inadequate manpower, facilities and research must be overcome.

The lack of knowledge concerning the causes, prevention and treatment of mental illness is crippling all our efforts. It has been said that our knowledge of mental illness today is about the same as our knowledge of infectious diseases at the time of Pasteur. Knowledge is meager not only because of the extreme complexity of the problem, but because of the relative lack of support given to the study of mental illness.

Totals spent in the United States for medical research are estimated at $120,000,000 a year—for psychiatric research, between $2,000,000 and $2,500,000.

Modern research activities in psychiatry require substantial financial support. Wherever necessary to supplement privately supported research, Federal, State, and local funds should be made available to finance investigations into the problems of mental illness.

Grants-in-aid and fellowships for research, now carried on under the National Mental Health Act, should be expanded so that investigations on mental illness become more nearly commensurate with the magnitude of the problem.

In virtually every area of mental illness we have a pitifully small body of knowledge with which to work. This calls for extensive research along many lines.

Basic Study

Considerable work is needed to understand the basic factors underlying normal brain activity and the influence of heredity in nervous and mental illness and feeble-mindedness. Anatomic, physiological, and chemical research is greatly needed in such fields as brain metabolism, electrical potentials, and autonomic relationships with emotion and thought.

Treatment

New methods of treatment are badly needed for the large number of persons suffering from psychoneuroses as well as for the vast numbers of mentally ill that fill our mental hospitals today. Present methods are slow and costs are prohibitively high. Treatment must be divided into both preventive and therapeutic methods. There is not a single existing method that would not warrant much research—individual and group psychotherapy, occupation, education, recreation, chemical methods, surgical methods, mechanical methods, shortened analysis.

The Normal

We know little about what constitutes a normal individual. Investigations in this field would include the structure and the physiology of the personality as well as the psychopathology of everyday life; the reactions to stress and the methods of maintaining mental health; and cultural variations.

Prevention

There is a fertile field for inquiry in preventing mental illness in childhood, into the developmental factors that determine the personality and their contribution to the formation of character. Organized information for parents to use in the guidance of a child is equally vital. The various factors of mental illness in relation to our aging population should be investigated.

Social Problems

Further inquiry and development of psychiatric techniques are needed in relation to delinquency, crime, and alcoholism. Mental health studies in industry involve improving morale for higher production, finding the mental and personality basis for absenteeism and accidents, and determining the psychological factors involved in labor-management relations.

MORE MANPOWER NEEDED

The shortage of psychiatrists is aggravated by uneven distribution. Few practice in cities of less than 50,000. Many States have no psychiatrists at all except those in State hospitals.

Even in our mental institutions, the shortage of psychiatrists is acute. The present national ratio is one to every 300 patients; in some hospitals, it is less than one to every 1,000. We currently have 1,319 psychiatrists in State hospitals. At least three times as many should be added.

There are now 1,000 qualified psychiatric social workers. Ideally there should be one psychiatric social worker per 10,000 population, indicating a total current need for 14,000.

Out of a total of 318,000 nurses, about 5,500 work in psychiatric hospitals. This means that 1.7 percent of our practicing nurses take care of nearly 50 percent of the patients in all hospitals on any given day.

The Nation must have more psychiatrists in private practice distributed to serve all areas and, ultimately, preventive psychiatric services throughout the country. Psychiatric workers should be available to work not only in clinics and general hospitals, but in all social agencies, such as churches, schools, welfare departments, and courts.

Special emphasis is needed on psychiatry in medical colleges, not only in regular curricula but in postgraduate courses, so that

general practitioners may have a wider knowledge of mental disease and mental health.

Training Programs

The shortages of psychiatric personnel are so great that only all-out efforts can even begin to meet needs. In all psychiatric and related fields, there are too few training centers and teachers.

Under Federal programs, there have been sharp increases in the last six years. Largely as a result of the vigorous training programs stimulated by the Veterans Administration, the number of medical students entering postinternship residencies in psychiatry almost doubled between 1942 and 1946. These programs, combined with the resources of the National Mental Health Act, almost doubled the total residencies again in the next two years.

The training program under the National Mental Health Act must continue to strengthen existing training facilities and establish new ones where needed.

A major consideration in this regard is to distribute training centers geographically so that they will be within a reasonable distance of students in all areas. In all training efforts, the selection and training of future teachers in psychiatry and allied fields should be stressed.

In order to overcome the financial barriers to professional training, the program of stipends under the National Mental Health Act should be extended to give adequate numbers of well-qualified candidates the opportunity for training.

The funds required for a comprehensive program to expand and strengthen training centers and to provide stipends for students would total over the next ten years approximately $75,000,000, beginning at about $6,500,000 in 1950 and increasing gradually until 1960. In the first years of such a program, it will be important to allocate the greater proportion of the funds for more and better centers. In 1950 the recommended ratio should be two-thirds for centers and one-third for stipends. As the program continues, an increasing proportion would be allotted for stipends.

A Nation-wide training program should provide for courses in psychiatry to orient public health personnel, general physicians, and specialists other than psychiatrists, miscellaneous hospital personnel,

probation officers and staffs of institutions for delinquency and dependency, vocational placement counsellors and rehabilitation staffs, management staffs in industry, shop stewards in labor unions, lawyers and judges, clergy and religious educators, teachers, recreation and group workers, law enforcement officers and others in public service. For mental health in its preventive sense is a point of view—a healthy understanding of the basic factors of living together. Each group in the country working with people and serving them should be given an opportunity to acquire the skills of good interpersonal relationships.

MORE AND BETTER FACILITIES

There are, in general, three types of psychiatric facilities: (1) All types of hospital accommodations for the mentally ill; (2) out-patient services for early detection and treatment; (3) non-psychiatric services, where there is opportunity for recognition and treatment of persons with mental and emotional disorders long before they would seek help from a specialist.

All three types of facilities are inadequate.

Mental Hospitals

Conditions in our State mental hospitals represent one of America's most disgraceful medical situations. There is overcrowding of 20 to 70 percent. Actual space is inadequate.

There is a 50-percent shortage of attendants and an 80-percent shortage of trained nurses. Public mental hospitals have a 75-percent shortage in psychiatrists. The per capita daily cost of patient care in mental hospitals throughout the country averages approximately $1.50. These meager funds mean lack of bedding, insufficient clothing, inadequate diet. One result of this poor support is that the majority of State mental hospitals do not give treatment. They give custodial care, often poor at that. Almost nothing is done for the patient as an individual.

A first consideration is the need for providing adequate funds for the proper hospitalization and treatment of the mentally ill. If States are not able to bring about substantial improvement in mental hospitals, steps should be taken for assistance by the Federal Government under the National Mental Health Act.

The Hospital Survey and Construction Act of 1946, discussed fully in chapter 3, authorizes Federal aid in building, but the small-

ness of the appropriation and the necessary priorities for general hospitals require further action to assure facilities for mental patients.

Clinics for Prevention

Community clinics can be of great strategic value in achieving optimum mental health. The practicing physician is the foundation of a sound mental health structure, and we cannot overemphasize the need for an adequate supply of psychiatrists and psychiatrically oriented general physicians. But of equal importance are the services of the community mental health clinic. It can make highly efficient use of professional personnel through the team approach which combines the skills of the psychiatrist, the psychologist, the psychiatric social worker, and the psychiatric nurse. It can provide easy access to people in the community for early diagnosis and treatment of emotional disturbances when chances of cure are greatest.

Our 600 psychiatric clinics should be increased as rapidly as possible, consistent with maintaining quality of service, until we have one for every 100,000 persons; they should be located so that rural people also have ready access to them. All existing clinics with qualified personnel should be subsidized by State and Federal Governments so that they may be used for training more personnel.

Children's Services

The clinics recommended above should provide preventive mental health services for children as a first priority.

For emotionally disturbed children who cannot be helped in their own homes or in foster homes, study and treatment institutions may be needed.

It is recommended that institutions and day care centers for the psychiatric study and treatment of children be more widely established and that psychiatric help be organized as an essential function in institutions for handicapped children.

General Hospitals

The practice of providing out-patient services in general hospitals for mental illness should be extended. One of the most

important aspects of this type of service is that it removes the stigma that attaches to mental illness in popular thinking by associating psychiatric treatment closely with other health services.

PROGRAMS OF PREVENTION

Federal, State, and local governments should provide funds so that psychiatric services will be included as a regular part of the activities of such organizations and institutions as the school, welfare departments, recreation organizations, law enforcement bodies, public health departments, and industry.

We must undertake a major campaign of public education to remove the stigma from mental ill health; to develop a sound public understanding of the nature, treatment, and prevention of psychiatric disorders; to stimulate active public support and use of sound mental health programs.

Healthy Maturity

Fifth Health Goal

To enable everyone in the Nation to enjoy a healthy, active, and productive maturity, by controlling chronic diseases—the greatest single barrier to achievement of this goal—and by relieving the other physical, mental, and social problems of adult life.

Two facts lend especial importance to all efforts for better health among people of mature years.

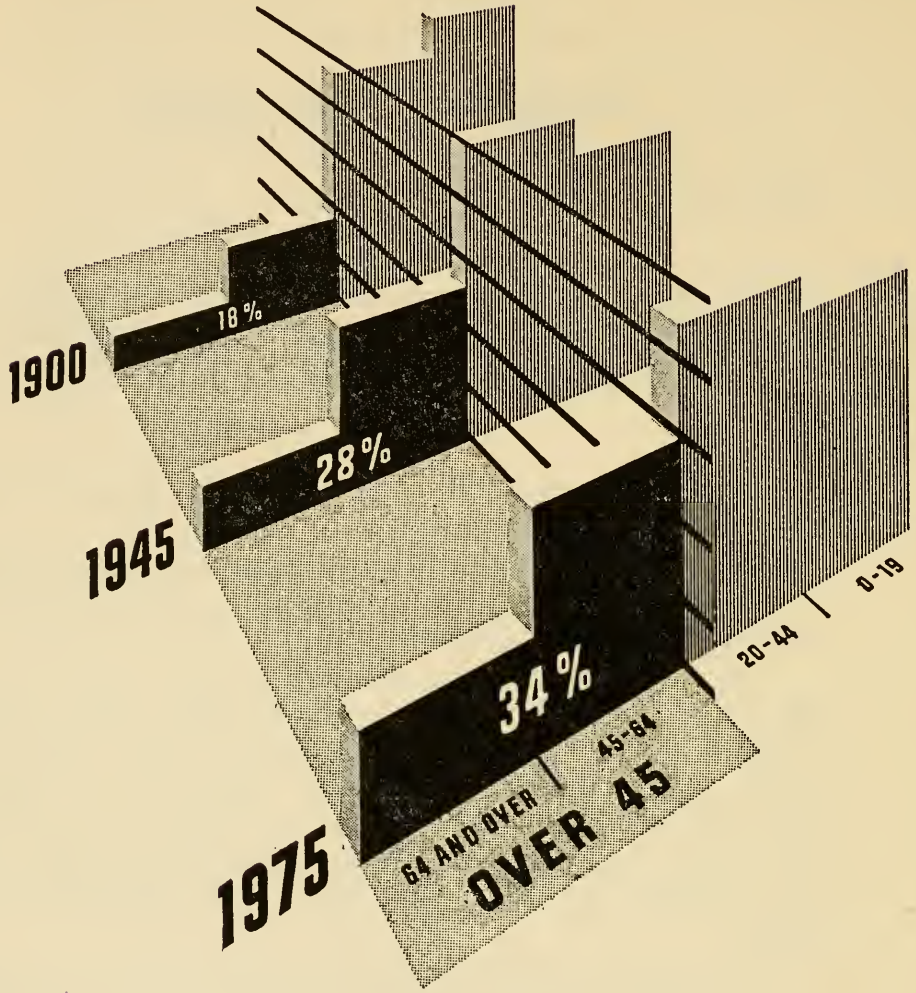
One, the population of the United States is, as a whole, growing older; the other, chronic diseases, which are the particular bane of older people, are on the increase.

Half of the population is now over 30 years old, whereas in 1800 the median age was 16 for the entire country. We now have 10,000,000 people over 65 years old; by 1975, their number will probably have doubled to 20,000,000. Moreover, more than a third of the entire Nation, by that time, will be 45 years old or more, whereas this age group—45 and older—comprised only 18 percent of the population in 1900. (See chart, Our Population Grows Older.)

This population trend will mean a further increase in chronic diseases unless, in the next 25 years, we can make rapid progress toward bringing them under control. While chronic diseases attack all age groups, they are most frequent among older people, and they cause almost three-fourths of all the deaths that occur in this country every year. (See table, Deaths From Chronic Diseases, on following page.)

In addition, they are responsible for 70 percent of all invalidism and partial disability—about 2,500,000 invalids, probably over four times as many partially disabled. This toll, with the incident sickness of chronic diseases, costs the Nation about $11,000,000,000

OUR POPULATION GROWS OLDER



DEATHS FROM CHRONIC DISEASES, 1945

Total deaths	1,402,000
Deaths from chronic diseases	1,014,000
Heart disease	424,000
Cancer	177,000
Brain lesions	129,000
Nephritis	83,000
Tuberculosis	53,000
Diabetes mellitus	35,000
Other chronic conditions	113,000

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every year in lost production. The cost to individuals, and to families, will be known to everyone who reads this report since chronic disease sooner or later touches nearly every family.

It is apparent that we must contrive to bring these cripplers and killers of the people under control if we are to improve the general health of the Nation to any significant degree.

In a very real sense, better health in the adult years—healthy maturity for all of us—is the single all-inclusive goal of our national health program. All that is being done to promote general health will contribute, but special programs are equally essential. We must study the aging process and its social and economic effects, as well as its physical and mental implications. For chronic diseases, we must expand our research and, meantime, employ all the means science has given us to prevent them, to check their progress in individual victims, and to help the chronically ill enjoy, and profit from, the fullest possible measure of productive life.

Social and Economic Problems

Many social and economic changes adversely affect the lives and health of older persons and, through them, the whole community.

Industrialization, with its speeded-up processes, its reduced dependence on individual craft skills, and its widespread practice of discarding older workers, creates an economic uncertainty in older individuals which helps undermine health.

The upward shift in the age composition of our population will bring these problems into increasingly sharper focus. As the average age of workers rises, older people will be increasingly responsible for maintaining the volume of national production and wealth. If many older people become prematurely debilitated and dependent, it not only will cause them needless suffering, but will throw the heavy burden of their support upon the working, producing part of the population. Premature loss of their contribution to the national wealth could cause a decline in total national earning power and production, seriously reduce our domestic market and sharply reverse our present steadily rising standard of living.

These threats to national welfare and to national security will lend a special urgency to all efforts to promote the health of older people, but even the best of medical care and services cannot do the job alone. Our national thinking about older people is at fault. It will be necessary to make intensive efforts to alter national attitudes—in the light of changing population factors—toward older people and their place in the national life and the national economy.

ACCENT ON MATURITY

As a young and pioneering Nation, the United States has kept its accent almost exclusively on youth. National thinking has stressed the value of rapid growth and expansion, of the drive and boundless energies of youth which they require. The Nation does need that vigor; it also needs the wisdom and balance that come with sound maturity, as well as the productive power of older people.

It is not economical, as it is not humane, to waste and exploit our human resources. We should discard the destructive concept that a man is "worked out" at 40 or at any other specific age.

Certainly, it will be necessary to reconsider the attitude we adopted during the depression toward older people and toward our own future. Old-age insurance provisions and employment practices put into use at that time emphasized early retirement in order to reduce the total labor force.

For the future, our purpose must be the reverse of this—to enable individuals to maintain their earning and living powers as long as possible, and at the highest levels possible before pensioned retirement. Humanity and the national interest require no less.

A PROBLEM IN EDUCATION

Changes in national attitudes can be accomplished only by widespread effort toward education. The concept that the aging group, and the partially disabled, are a liability to the country can be eradicated only by broad exploration of the capabilities of such people.

To accomplish these purposes, I propose to work for cooperative educational campaigns among the public, among labor unions and employers' groups:

1. To encourage employers to hire and to retain in employment older persons and those partly incapacitated through chronic disease or other causes. Surveys have indicated that, from the employers' standpoint, the handicapped worker offers such advantages as greater loyalty, less absenteeism and reduced tendency to change jobs. Employment of older workers should logically offer the same advantages, plus the experience, judgment, and skill of greater maturity.

2. To show employers the desirability of making health maintenance services available to all employees and of providing, for elderly or partly disabled employees, careful selection of jobs to which they are best suited, special equipment and apparatus, rest periods, and adjusted hours of work.

SOME CONSTRUCTIVE STEPS

Efforts should be directed toward accomplishing selective retirement, based on individual capacity rather than age.

This could be accomplished through establishing retirement boards in industry and government—including medical, psychiatric,

and administrative personnel—to determine the physical and mental fitness of individual workers. A study of the experience of such boards would be invaluable in assisting their wide establishment throughout the country, as would research on the relationship of individual disability to specific jobs.

Both public and private employers would profit equally with employees from working out techniques for gradually relieving individuals of more taxing responsibilities as they develop the limitations of advancing age, by keeping pay commensurate with productivity and by full use of the possibilities of vocational retraining.*

Industry and governments have made commendable progress in development of old-age retirement provisions for employees, but existing programs are not yet adequate. The conditions of retirement, the pensions paid, and the type and coverage of such programs—all need improvement.

Positive steps in the areas suggested here will help to ease some of the social and economic factors that arise from the increasing age of our population, to maintain production and purchasing levels, and to assist older people toward greater security and better health.

To lend Federal assistance in this total effort, I have established a committee within the Federal Security Agency to study the entire range of problems related to an aging population. Programs for social security, health, education, job-placement and rehabilitation—all found within the Agency—will be examined to determine how they can be modified and strengthened to assist the older age group.

*This phase of rehabilitation is discussed in detail in chapter 8.

Chronic Disease—The Major Front

Chronic diseases do not reserve their blows exclusively for the aged and infirm—more than half of all their victims are under 45—but the danger of developing a chronic disease does increase as people grow older. People between 45 and 64 are four times more likely to have a disabling chronic disease than are people between 15 and 24. Above 65, the chances are six times as great. (See chart, Chronic Diseases Increase With Age.)

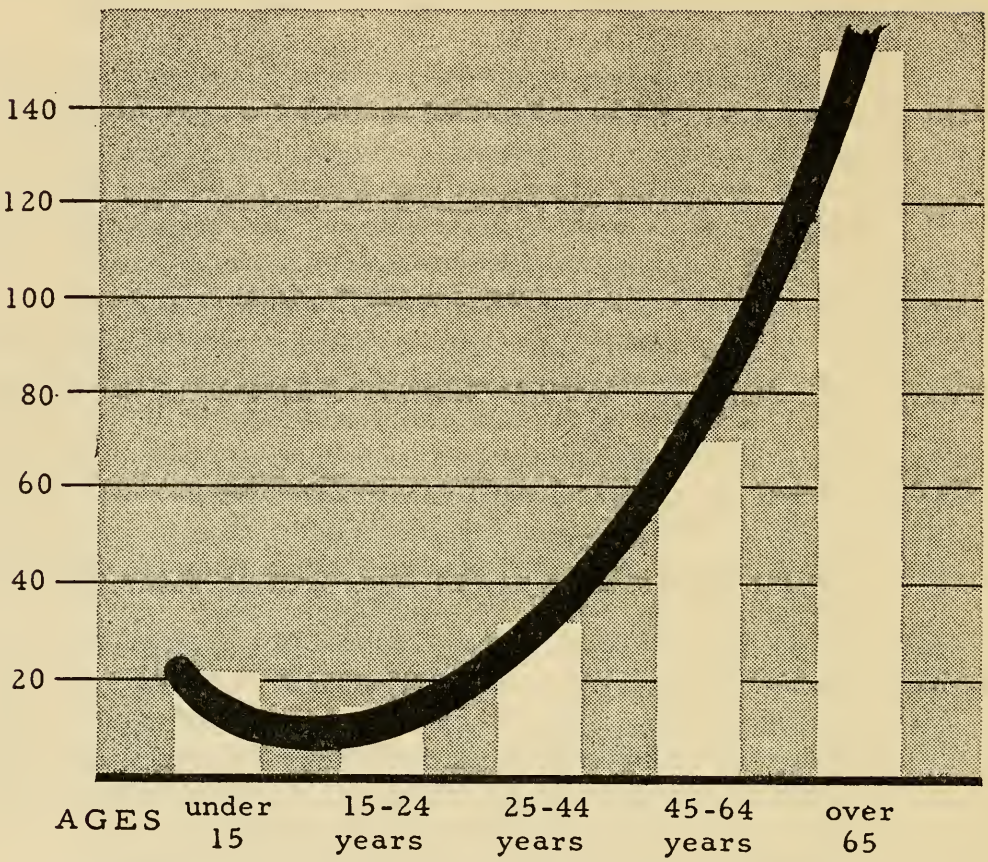
At least a sixth of our entire population—more than 25,000,000 individuals—is numbered among the victims of chronic diseases. The implications to the national economy have been made clear. But no dollar tag can be placed on the human suffering that these diseases cause, or on the effect they have upon the families of the victims. They can cause psychological disturbances severe enough to break up a home. They place a severe strain on family finances, especially if the wage earner is stricken. Any family with an income below $5,000—and that includes 80 percent of the population—will be hard put to face the costs of a serious chronic illness (see chapter 4). Moreover, statistics show that chronic illness occurs almost half again as frequently among the lowest income groups as among those in even slightly higher brackets. This is reflected in the fact that families are frequently reduced to dependency on public funds as a result of such sicknesses.

The diseases that cause such havoc have familiar names—diseases of the heart, hardening of the arteries, and high blood pressure; nervous and mental diseases; arthritis and kidney ailments; asthma and hay fever; tuberculosis, cancer, diabetes, and hernia.

Stamping them out, or even bringing them under control, will not be easy. Our past victories over communicable diseases, however, and our success in improving child health promise that a carefully planned, well-executed effort to solve the problems of chronic disease will sharply reduce the suffering and losses that now occur.

CHRONIC DISEASES INCREASE WITH AGE

(cases per 1000 population)



Illnesses diagnosed as chronic, exclusive of tuberculosis and mental disease, causing at least 7 days disability in a year. Source: "A Program for the Care of the Chronicialy Ill in New York State," 1947.

Organizing The Attack On The Chronic Diseases

The problems presented by chronic diseases cut across the entire field of health—the training of professional personnel, public understanding, the provision of facilities, community and State planning, and research. They touch all communities of our country—urban and rural, local, State, and national—and all groups, regardless of religion, nationality, or race, or ability to pay for their needs.

Our program for the control of chronic disease must be equally universal. As in our general health programs, local communities, agencies, medical personnel, and facilities necessarily must bear a major responsibility for providing services to the chronically ill. State and Federal Governments should offer leadership, sponsor research, provide some financial assistance, and set up and maintain machinery of cooperation.

Three principles should govern the program:

1. The basic approach to the conquest of chronic diseases must be to prevent them.

2. The emphasis for victims of these diseases must be on arresting the progress of the ailment and on helping the individual to maintain normal living.

3. The emphasis for the medical profession, business, industry, and the general public must be on the capacities and abilities of the victims of chronic diseases, rather than upon their limitations.

Planning—The Basis Of The Entire Program

The planning of a coordinated program will necessarily begin with establishment or designation of national, State, and local agencies, assisted by representative advisory committees, to undertake the task. Such efforts should be correlated with all other health work and tied in with the social programs of the communities in citizens' health councils, as suggested in the discussion—in chapter 9—of the need for community organization and action. The many problems of organization of services, of setting up central information on services and facilities, of wide public and consumer representation on the planning bodies are emphasized there. The broad-scale effort required to bring chronic diseases under control particularly depends upon this type of action.

A number of communities have already established such planning bodies on chronic disease. In Chicago, Milwaukee, and Philadelphia a "Central Service for the Chronically Ill" has been set up. In other communities coordinated planning is done by councils of social agencies and similar bodies.

On the State level, a coordinating group for chronic disease services is needed to stimulate and guide the development of local and regional planning.

State planning has been formalized in Connecticut, Illinois, Indiana, Maryland, Massachusetts, and New York. New Jersey, although it does not have an official comprehensive plan, has developed services for the chronically ill which are widely commended. In California and Indiana the State health departments have established special divisions or units to deal with the problem of chronic disease. These activities presage further rapid developments of this nature. All States can plan in similar fashion.

The efforts of Government and the many private national organizations concerned with chronic disease need to be brought into a planned and coordinated relationship. A beginning has been made by the Joint Committee on Chronic Disease of the American Hospital Association, American Medical Association, American Public Health Association, and American Public Welfare Association.

The National Health Assembly's Section on Chronic Disease and The Aging Process strongly recommended that the work of this committee should be encouraged by the provision of private funds and by Government support, so that it can study the entire problem of chronic disease.

I endorse this recommendation. In addition, I am establishing within the Federal Security Agency an appropriate body to coordinate planning and program activities in the field of chronic disease by the various bureaus of the Agency. This body will also seek coordination with other Federal agencies working in related fields.

Prevention

Although the cause of many chronic diseases remains obscure, there is evidence that some result from the accumulated effects of infections, injuries, dietary deficiencies, and of emotional and physical strains. Improvement in hygiene, success in preventing acute illnesses, and good medical care generally will, therefore, help prevent chronic illness.

Since we cannot always prevent chronic illness, every effort must be made to prevent, postpone, and arrest disabilities that result from it. Early discovery and treatment are necessary so that minor abnormalities may be corrected before serious disabilities develop.

HEALTH INVENTORY

The methods used in the programs that have been so successful in conserving the health of infants and children should be modified and directed toward promoting health in adults. Most important in this connection is the "health inventory," which, in addition to a periodic physical checkup, should include an analysis of the individual's habits of life, his drives and attitudes, and the social factors affecting his health. Wise guidance in hygiene, including nutrition, is essential.

The health inventory is particularly applicable to persons apparently in good health. They may be suffering from an incipient chronic disease, the symptoms of which have not appeared.

Mass screenings of large population groups, undertaken to discover tuberculosis, cancer, diabetes, heart disease, or some other ailment, should be combined, as is now being done in some pilot programs, so that a single adequate diagnostic study can reveal any or all disorders that a person may have.

MORE RESEARCH

Although considerable research is now concentrated on chronic diseases, the total is only a fraction of what is needed. The future distribution of funds for research should be more closely related to the social and economic importance of chronic diseases.

A recent study of the funds spent for medical research indicates, for instance, that for each death due to infantile paralysis more than $1,200 a year from private and public funds was spent for research; more than $100 for each death due to other acute infectious diseases—as measured against $50 for each death due to cancer and $3 for each death due to cardio-vascular disease: the two major killing and crippling diseases.

Investigation is urgently needed into the causes of specific chronic diseases and in methods of early diagnosis. Research is also necessary on the social, psychological, and vocational aspects of chronic illness.

EDUCATION

New emphasis is important in the education of all types of health personnel that care for the chronically ill. The points made in this report—the possibility of early diagnosis in preventing or checking chronic diseases, and of rehabilitating patients—have been

stressed by all students of the problem. The need for postgraduate and refresher courses in these fields is especially great, as is the emphasis—typified in the "health inventory"—upon the total health picture of a patient, and the possibility of multiple causes of disease, rather than upon treatment of a single disease.

Greatly expanded programs are needed to help the general public develop better understanding of the nature, causes, treatment, and prospects for recovery or arrest of chronic illness.

Programs for Care Of Chronically Ill

As a Nation, we have serious deficiencies in our provisions of facilities and services for the care of victims of chronic disease. These patients, at various stages of their illnesses, may require supervised care at home, and in hospitals and their affiliated supervised nursing, convalescent, or boarding homes. Rehabilitation services should be an essential part of all of these provisions.

The exact extent of the deficiencies in various categories is difficult to measure, but experience indicates severe shortages both in facilities and personnel.

HOME CARE

Approximately 70 percent of all persons with chronic disease can be cared for at home, provided adequate supervision and assistance are available. Facilities for home care, therefore, are fully as important as institutional facilities. They should include at least the following services for the patient:

(1) Medical care, to be provided by a private physician, clinic physician, or through an extension of hospital programs to include home care; (2) full or part-time nursing care, to be provided by visiting registered and qualified practical nurses; (3) visiting housekeeper or homemaker services, to be provided for those patients who need assistance in taking care of themselves; (4) social work, to assist in family planning and adjustment; and (5) restorative services, including occupational therapy, physical therapy, rehabilitation, vocational guidance, and recreation.

The soundness of home care programs that include these services has been demonstrated in a number of communities—notably New York, Syracuse, and Chicago—where hospitals have undertaken to provide such services.

There are few precise indices for calculating adequacy of home care facilities. One that might be used, however, is visiting nurse service. Results of a New York State survey* of chronic disease indicate that one public health or visiting nurse for every 2,000 population would be required if bedside nursing service is added to their other duties.

On a national scale, 72,000 public health and visiting nurses would be needed. As of January 1, 1947, the Nation had only 21,500 public health and visiting nurses. The deficit amounts, therefore, to more than 50,000 nurses.

Housekeeper Services

There is urgent need for the extensive provision of visiting housekeeper or homemaker services for care of the chronically ill. Although in a few communities voluntary and public agencies furnish these services to families when a mother is ill, there is practically none for aiding the chronically ill and aged. A recent survey found only two cities in the Nation that now offer such service to adults other than mothers with small children.

Appropriate voluntary and official agencies could train and employ persons to assist in home care of the chronically ill. Sporadic experiments in providing housekeeper service have been made from time to time. The most extensive activities occurred under the WPA program, in which housekeeper aide projects were set up in some communities in all but four of the States. A project in New York City was particularly devoted to service to the chronically ill and infirm aged. With the cessation of the WPA, most of these projects were abandoned. They amply demonstrated, however, the value of housekeeper services in improving the care of the sick in their own homes. A program of welfare services in connection with the administration of public assistance programs is needed to help State and local agencies develop this work.

Group Living

For the aged and handicapped who are able to remain at home but unable to manage without some protective services, group living arrangements can be further developed as a desirable alternative to entering an institution. Congregate residences such as apartments

*A Program for the Care of the Chronically Ill in New York State, New York State Commission to Formulate a Long-Range Health Program, 1947.

and cottage colony plans, with shared facilities and services, offer protection while assuring privacy, considerable independence of action, and opportunity to be a participating member of the community.

Some of the national religious organizations are recommending to their member churches that they follow the lead already taken by a few churches whose program for the care of the infirm aged includes cottages built around a central or "mother" institution. Such arrangements make it possible for people to carry out the responsibilities of normal life, thus postponing the day of inactivity. Similar schemes may well be applicable for the chronic sick of younger age groups.

Housing units may be—and in a few communities, notably Cleveland and New York, have been—built with facilities which offer this group of persons the cherished privacy of their own home and the cafeteria and other services necessary for them to maintain their independence.

Foster Homes

For those who cannot manage such group living arrangements, or live with family or friends, foster home programs could be developed. The methods used in the mental hygiene and child welfare programs to locate, increase, and supervise foster homes can be adapted to this purpose.

INSTITUTIONS

The need for hospital and other institutional facilities for the chronically ill is so great and so immediate in both urban and rural areas that it can be met only with the financial assistance of local, State, and Federal Governments.

Hospitals

The Hospital Survey and Construction Act of 1946 stipulated that there should be two hospital beds per thousand population for chronically ill patients, exclusive of those for tuberculous or mental patients.

On this basis, we need 285,000 hospital beds for chronic disease patients. We now have, according to State surveys, only 39,000 beds.

Many communities report that large numbers of the chronically ill are being accommodated in facilities of general hospitals designed

primarily for the care of acutely ill patients whose stay is relatively short. Since most of these institutions are designed and geared for short-term patients, they lack many of the facilities that the chronically ill require, such as provisions for physical therapy, occupational therapy and rehabilitation, as well as recreational facilities—sun decks, sitting rooms—and other features necessary for the long-term patient. Not only is the care provided unsuited to the needs of the chronically ill, but it is more expensive than it would be in appropriate facilities.

General hospitals should be encouraged to develop units specifically designed to meet the needs of the chronically sick, and these should be built in the closest possible relation to medical teaching centers. Such an arrangement avoids duplication of facilities and provides for professional personnel a much needed opportunity for experience. It also permits patients to be transferred readily when, as so frequently happens with the chronically ill, changes in their condition require different types of treatment.

Specialized chronic disease hospitals will also be needed in large cities and they, too, should be closely related to medical schools and teaching hospitals.

Related Facilities

Many chronically ill patients who do not require active and continuing hospital care cannot, or should not, remain at home. For them, intermediary facilities are necessary in nursing homes. At least 375,000 of the people who receive old-age assistance are bedridden or in need of considerable care, and many of these are in private nursing homes. Another 25,000 aged persons are now in public medical institutions.

There are far too few public and private nursing homes, and few have adequate standards of care; nor has money been made available to assure or maintain quality. The failure of many States to bring such homes under adequate licensure is another factor that impairs quality.

Facilities of this class are not included under the terms of the Federal Hospital Construction Act, nor were needs for nursing homes included in surveys made under this act.

The Nation's needs can, however, be estimated on the basis of the New York survey, which found that, outside of New York City and exclusive of tuberculous and mental patients, the State needed

between 2.5 and 3 beds per thousand population in nursing and convalescent homes to care for chronic disease patients. The State Commission considered this a conservative estimate.

On the basis of three per thousand, the Nation needs some 430,000 beds in qualified nursing and convalescent homes. It has not more than two-thirds that number; our deficit, thus, is between 125,000 and 150,000 beds.

Provision of enough nursing and convalescent homes, adequately equipped and supervised, is one of the major tasks for which the State and local planning groups can assume responsibility.

Rehabilitation—A Neglected Area

Of key importance in the entire program for care of the chronically ill are rehabilitation services. The vocational elements of rehabilitation are discussed elsewhere, but the ability to return to competitive employment should not be the sole criterion of success in rehabilitation. Many victims of chronic disease, with help through physical or work therapy, could take a much more active part in normal living. Even being enabled to care for their personal needs would be a marked gain for many.

Numerous examples of the gains made by victims of chronic disease through rehabilitation were cited by the National Health Assembly. A girl, bedridden for 14 years as a result of infantile paralysis, was enabled through six months' training to become self-sufficient, to live alone, and to hold a full-time job from which she was absent only once in 14 months—the day of the New York blizzard.

An arthritic cripple, his entire body immobilized except for his hands and arms, was enabled through training to walk, to care for his needs, and later to take vocational training. These are extreme cases. Often, brief psychiatric treatment, short periods of therapy, the provision of mechanical devices to assist in easy movement and self-care, association with other persons who are similarly handicapped but trained to independence of movement, will overcome obstacles that are making invalids of people actually able to function with moderate efficiency in spite of chronic ailments.

The Nation needs much more of this kind of service. There are

few victims of chronic disease so disabled that they cannot benefit from rehabilitation.

To accomplish planned convalescence and rehabilitation for those partly disabled by chronic disease, we need:

1. Increased understanding among physicians and others serving the chronically ill and aged of the possibilities and techniques of rehabilitation and an increased number of trained rehabilitation, medical, and supporting personnel. There is a critical shortage of trained personnel in all these categories.

2. Increased emphasis on the establishment of rehabilitation programs in general and special hospitals, convalescent homes, nursing homes, homes for the aged, and other types of public and private institutions, and expanded facilities for these purposes; and

3. Increased public as well as professional understanding of the medical, social, and economic implications of chronic disease and an aging population.

Financing The Attack On Chronic Diseases

Additional local, State, and Federal funds, as well as private money, are indispensable to meet the many problems of chronic disease on a national scale. They are needed for research, control programs, for construction and maintenance of facilities, and for services to individuals.

Specific recommendations included in other chapters of the report will assist in many aspects of the program—for instance, in hospital construction. In addition, Federal funds will be required especially for the following purposes:

1. To expand research programs on chronic diseases now being carried on with help from the Federal Government;

2. To expand programs of prevention;

3. To assist in financing medical care for victims of chronic disease.

The last area—help in paying for the costs of treatment and care for victims of chronic disease—presents a very grave problem. Voluntary insurance systems offer no protection in this field since

they specifically exclude certain chronic diseases from their benefits, or else place a time limit on services that would be far outrun by the needs of chronically ill patients. It has become clear also that philanthropy cannot meet the increasing needs of people in this group. There is no other recourse except that governments—local, State, and Federal—should lend financial assistance.

Persons who are residents of public medical institutions can be assisted by amendments to the Social Security Act, which now prohibits payments to such people. A medical assistance program to help States in financing home care for chronically ill persons has long been recommended by all health, welfare and medical groups. A system of Government health insurance that provided for physicians' care in home and office, and which further provided nursing services, would relieve the situation. All these steps will help, but only fully coordinated programs—properly supported by all available sources of funds—will prove wholly adequate to the task.

chapter 7

Rehabilitation for Handicapped

Sixth Health Goal

To rehabilitate the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the most nearly normal life and work of which they are individually capable.

Each year about 250,000 men and women are so disabled by injury or disease that they become incapable of holding a job or of enjoying a normal life. The vast majority of them can be helped through restorative medical care, vocational training, and the other services generally grouped together as rehabilitation, to take their places as productive members of their communities.

Altogether, there are many million handicapped people in the United States today. They include not only those who have been incapacitated in accidents but also the mental patients of State hospitals, the deaf and the blind, people injured or crippled at birth and—by far the largest group—the victims of chronic diseases. Obviously, many of these people cannot be enabled to return to competitive community life, but surveys have indicated that 1,500,000 of them—not including veterans disabled in service—would benefit greatly from rehabilitation services. Relatively few of this number, and of the 250,000 who become disabled every year, suffer impairments so severe that they must always lead sheltered lives.

For generations our practice was to ignore the possibility that these people might return, after they were stricken, to active life. They were generally relegated to invalidism, their disability accepted as a permanent barrier between the individual and any further development of his capabilities as a human being or as a worker.

Private and voluntary agencies were the first in this country to break with this wasteful and inhumane attitude, and to institute rehabilitation services. Until 1920, the only help to the crippled and disabled was supported by these groups. In 1920, however, national legislation—the Vocational Rehabilitation Act—made a limited Federal-State beginning on the problem. Emphasis was on vocational retraining, counseling, and job placement. Medical services necessary to reduce individual handicaps were insignificant parts of the program. An average of 9,000 persons was rehabilitated each year—a total of 210,000 between 1920 and 1943.

Experience under the Act demonstrated the importance of medical and related services. The work of the armed services and of the Veterans Administration with the much smaller number of persons disabled during the war helped to point the way. Since 1943, when the Barden-LaFollette Act was passed, the Federal-State program, administered by the Office of Vocational Rehabilitation in the Federal Security Agency, has been able to provide some of the physical restoration and other medical services designed to lessen the effect of a person's disability. It is still confined to helping disabled people become able to work, to returning disabled men and women to gainful employment, to assisting people in danger of losing their jobs because of a disability to stay in a suitable employment, and to helping to better-paying jobs people whose disabilities permit only part-time or temporary work.

THE PROGRAM

The kind and amount of rehabilitation services provided vary according to the needs of the individual. Some persons need only medical and vocational diagnosis and counseling to enable them to return to work. For others, comprehensive services are needed—including maintenance, hospitalization, physical restoration, vocational counseling, training, and selective job placement.

During 1947, under the Federal-State program, medical examinations were purchased for about 75,000 disabled persons, and psychiatric examinations for 2,000. Artificial appliances were provided for nearly 12,000 persons, and medical, psychiatric, surgical, and other medical treatment was extended to about 11,000 people. Hospitalization and related care were provided to about 7,500. Training of all types was purchased for 38,000 disabled persons.

Between 1943 and 1948 the Federal-State program rehabilitated some 219,000 disabled workers. Last year, 191,000 persons received services and 53,000 of these completed rehabilitation. At the end of the year, nearly 118,000 persons still were receiving services under the program. Three-quarters of the total number of people who have been rehabilitated since 1943 were unemployed at the time services were begun.

A large part of the burden of rehabilitation still is being carried by voluntary agencies, financed by public subscription and private philanthropy. They are performing an invaluable service to the Nation, putting up a staunch fight with inadequate funds in a field that requires millions of dollars as compared with the scant thousands which they can amass. They have pioneered in establishing facilities and in discovering and demonstrating new techniques for rehabilitation. Their continuing contribution is greatly needed.

NOT ENOUGH

All that the voluntary agencies can do, all that can be accomplished under the present Federal-State program, still falls far short of the Nation's needs. Only a small portion of those who require rehabilitation services are receiving them. Besides the small number of disabled workers who are receiving help, there are hundreds of thousands of other citizens who could benefit through rehabilitation. Injuries and diseases are crippling people far faster than the present limited program can provide rehabilitation for them.

Our first aim, clearly, must be to prevent disability. As we work toward our goals for health and medical care, the incidence of disabling illness may decrease, the accidents may be reduced. But we know that, in spite of all we can do, there will still be tens of thousands of men and women disabled annually.

Our goal must be to provide for all disabled people all of the rehabilitation services they need to attain the fullest possible life their disability permits. This is important to the Nation economically; it is life itself to the handicapped men and women. Full rehabilitation services, physical and vocational, should be available to all who need them, without regard to race, religion, place of residence, or personal economic status. By 1960, as a beginning, we should fully rehabilitate the 250,000 workers who are disabled every year.

Planning The Program Of Full Rehabilitation

The cooperation of many different institutions, organizations, and types of services is essential for complete and effective rehabilitation services. Physical restoration, hospitalization, psychological testing, maintenance, vocational counseling, training and selective placement services—all of these need to be organized as a team to assure that all individuals receive what they need for complete rehabilitation.

Great strides have been made during the past year in bringing together public and voluntary agencies, but much more needs to be done. Without further advances in coordination, the available facilities, skills and funds cannot be marshaled for fully effective services.

Coordination of services will need to be accompanied by a much stronger emphasis on the physical aspects of restoring the handicapped. Medical restoration and physical training and conditioning are still undeveloped in the Federal-State rehabilitation program.

MEDICAL SERVICES

The hospital where the disabling injury or illness is first treated is the place where physical rehabilitation should begin. Hospitals will require extra staff and facilities to undertake such work, especially for initiating physical therapy, occupational therapy, and other physical medicine services. It is extremely important that they be equipped to carry on this work.

Delay in the early stages of disablement places a handicap on ultimate restoration, as many histories of people assisted under the Federal-State program have demonstrated. A young man with both legs amputated above the knee, for example, received no rehabilitation help until five years after the automobile accident in which he was crippled. He spent those five years an invalid, confined to a wheel chair. Rehabilitation services supplied the necessary surgery to fit him with artificial legs, trained him in their use and restored his physical strength so that he could undertake vocational training. Three or four times as much effort and time were required to accomplish this as would have been necessary with early assistance. Had such services started in the hospital, he also

could have been spared years of invalidism and discouragement and gained five years of useful employment.

For many types of handicapped people, a combination of rehabilitation services over a period of years is necessary. Special facilities and workshops with highly trained personnel are required. People with heart disease or tuberculosis, for example, need help over a considerable period so that they can gradually develop and enlarge their capacity for work before entering competitive employment; otherwise, they may suffer a recurrence of their disease.

Centers

A planned system of hospital services, plus a similar system of rehabilitation centers will be needed to provide full physical restorative services before vocational work can begin. Hospital services will be included in many of the hospitals being constructed under the Hospital Survey and Construction Act of 1946. Rehabilitation centers, preferably connected with medical schools and base hospitals, must be planned for separately. They would be invaluable, not only for rehabilitation, but for centers of research, demonstration and personnel training.

There are several hundred facilities in the country which provide specialized rehabilitation services to the disabled. A few of these, less than 10, provide comprehensive rehabilitation services. The vast majority, however, provide only a limited number of services, usually for one or several types of disabilities. Eighteen of the several hundred were established by State rehabilitation agencies, or with their prominent participation; 16 more are being planned. A few of these are major rehabilitation centers providing a rather complete range of services; a few of the voluntary facilities are in the same category.

The Nation will need a total of 18 major rehabilitation centers, providing fully comprehensive services—in addition to more specialized units—to meet our 1960 goal of rehabilitating 250,000 handicapped workers. Facilities already established by private agencies should be tied in with such a Nation-wide system, and should be assisted with Federal-State funds under the program. Other local rehabilitation services would have to be developed in communities along with the expanding programs of hospital and public health services.

Federal appropriations for the current limited and inadequate Nation-wide program of vocational rehabilitation amount to $18,000,000 a year, State appropriations to $7,000,000. To reach our goal of completing medical and vocational rehabilitation of 250,000 workers a year, public funds should be increased gradually until, by 1960, Federal appropriations reach $70,000,000 annually, State appropriations $30,000,000. Not until substantial progress has been made in caring for these handicapped workers can the Nation plan to assist all of the disabled persons whom rehabilitation can restore.

Survey

Before a comprehensive expansion of rehabilitation centers and facilities can be undertaken, a survey should be made to determine exact needs and the most useful locations. Such a study would also indicate methods by which physicians, hospitals and public health services could cooperate in meeting rehabilitation needs.

Personnel

The lack of trained personnel—medical and nonmedical—is one of the most serious barriers to adequate provision of physical restoration services. At present, about 4,000 physical therapists and 3,000 occupational therapists are employed in hospitals.

To staff a Nation-wide system of physical rehabilitation facilities will require the recruitment and training of 2,500 to 3,000 medical specialists and 10,000 to 12,000 more therapists. Institutions of higher education could expedite training by including physical rehabilitation in medical, nursing and related curricula during the undergraduate years.

Accurate information about the need for nonmedical personnel, such as vocational rehabilitation counselors, is not available. It is safe to say that the number required would be several times the number of medical specialists and therapists.

Steps to assist in producing the needed numbers of rehabilitation specialists are part of the program for all medical personnel discussed in chapter 2.

Research

The improved rehabilitation techniques developed in the armed services and by the Veterans Administration demonstrate overwhelmingly the value of research directed toward the specific prob-

lems of the disabled. We need new knowledge, however, of the psychological and physical effects of disablement. We need new methods and techniques for the physical, social and vocational adjustment of disabled persons. We need especially to know more about what is necessary to prevent or minimize the disabling effects of blindness, amputation, epilepsy, various types of paralysis, and other disabilities. Studies would also assist in determining the actual capacities and aptitudes of the handicapped for various types of work.

Education

The extent of disability among the civilian population, the suffering and economic loss entailed, and the potentialities of handicapped people for being restored to more rewarding and productive lives, are not generally understood among the public, nor among the rank and file of the medical and other professional groups. As part of the plan for rehabilitating the disabled, it will be essential to conduct a program of information.

The available supply of specially skilled persons in the medical and allied fields could be employed much more effectively if there were broader understanding of what rehabilitation means, and what it can do in our communities.

Rehabilitation earns economic as well as humanitarian rewards. Many disabled persons and their families become dependent on public funds for support. If restored by rehabilitation, they not only become self-supporting, but as productive members of society pay back—if employed only 85 percent of their life expectancy—$10 in Federal income taxes alone for every Federal dollar invested in their rehabilitation.

The appropriations suggested here would pay dividends in every way. With them, the Nation can make a worthwhile start on its task of restoring to the handicapped their share of health, normal life, and productive years. Moreover, the national economy would gain far more in increased output than the costs involved.

chapter 8

A Good Start in Life

Seventh Health Goal

To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care and social, psychological and health services for all children and mothers in childbirth.

The foundation of positive health must be built in childhood. Everything we do to assure children a healthy start in life improves the chances of health in maturity.

Achieving physical, mental, and social well-being is a growing process that starts even before birth and continues, step by step, as a child gradually matures into an adult.

The very process of growing up creates special physical, mental, and social health problems which are quite distinct from the problems involved in protecting, maintaining, and increasing the health of adults. Children are not pocket editions of adults, requiring therefore only pint-sized doses of adult medicines. The health care they need is both qualitatively and quantitatively different.

Childhood is the period when every expenditure of effort in cultivating good health can yield the greatest dividends. It is also the period when neglect of health can be most costly.

In the last 20 years, the Nation has made great progress in child health, but the work is still far from complete.

162,000 people under 20 now die each year, although we have the knowledge and the skills to save the lives of nearly half of these.

Every 19 minutes an infant dies whose life could have been saved.

Every four hours we lose a mother in childbearing whom we might have saved.

The Nation's gains, nevertheless, have been notable. Our maternal and infant death rates, which used to be less favorable than those of six other nations, now stand with the best.

In the 10 years from 1936 to 1945, we cut the infant mortality rate one-third and the maternal mortality rate nearly two-thirds. Deaths from smallpox, diphtheria, whooping cough, and tetanus have been reduced more than 40 percent.

How Many More Lives Still Can Be Saved?

Many diseases strike most dangerously at children and require special effort to safeguard the younger members of the population. Mental care and nutrition also have special aspects for children. Services for handicapped children differ markedly from those for adults. Mothers and newborn children have particular needs for specialized medical and health care, but its provision depends to a considerable extent on the success of the total national effort to provide enough physicians and hospitals everywhere, and to remove economic barriers that limit people's use of such services.

Saving Mothers and Infants

The records of various States show clearly that many more maternal and infant deaths can be prevented. If every State had done as well as Minnesota in 1945, the lives of nearly 2,000 more mothers would have been saved; if every State had equaled Rhode Island's record, 28,000 babies could have been saved in that one year. But in New Mexico, for example, the maternal death rate was more than twice that of Minnesota, the infant mortality rate more than three times that of Rhode Island.

Even in Minnesota, where physicians studied all factors relating to mothers' deaths, the conclusion was that 75 percent of those who died could have been saved; the low infant mortality rate achieved by Rhode Island can also be reduced.

A mother and her baby also have a better chance of survival if their skins are "white" rather than "colored." The 1945 death rate for mothers who were not white was 165 percent higher than for white mothers, for infants 60 percent higher.

The importance of more and better trained doctors, more and safer hospitals, in saving lives of mothers and babies is pointed up by our successes in the last decade. Many of the gains made have been due to the steadily improving quality of obstetric care—generally inadequate in many States and unattainable to people of lower incomes or of minority groups that are discriminated against.

Thanks to the educational efforts of the medical profession, voluntary agencies, and the Government, more expectant mothers now go to a doctor for care by the third month of pregnancy. Many more among the lower income groups undoubtedly would go if there were an adequate system of prepaid health services to finance doctors' bills and if doctors were available.

Early examination and advice save many lives. New drugs reduce the risk of infections. Easily accessible blood for transfusions and early treatment of hemorrhage and shock prevent many deaths.

Newer methods of anesthesia are contributing to better health for mothers and babies, as are the discovery and study of "Rh" blood groups. Fewer operative deliveries are now considered necessary for mothers with diabetes, tuberculosis, heart disease, and toxemia.

Saving Children's Lives

Since 1933, the mortality rate for children between one and four years old has been more than halved; for children five through 14, it has been cut almost in half. For both groups, accidents are the chief cause of death. Among diseases, pneumonia and influenza cause most deaths of preschool children, while acute rheumatic fever and all rheumatic heart diseases rank first for the older group.

Children have a higher sickness rate than any other age group, except persons 65 and over. Many of these illnesses are what are called the relatively minor diseases of childhood, but this does not make them insignificant. They may—and often do—leave behind them conditions which handicap a child throughout life. Colds and other infectious diseases, for instance, may result in deafness.

COMMUNICABLE DISEASES

Of the 100,000 people who die each year from communicable diseases, excluding pneumonia, 20 percent are under 20 years of age.

Eighty thousand of all these deaths are due to 20 diseases for which preventive measures are effective. Even among the diseases for which we have no direct preventive, great improvements can be made in reducing sickness and death. The use of DDT to rid whole communities of flies and mosquitoes may be helpful in controlling many diseases.

Sulfa drugs are working miracles in reducing deaths from scarlet fever. Carefully controlled use of gamma globulin injections can increase immunity to measles. More use should be made also of the influenza vaccine found effective by the armed forces. In tuberculosis, there have been promising results in use of BCG vaccine for infants and young children.

DENTAL CARE

Some 20,000,000 of our school-age children—75 percent of all of them—need dental attention. The average child on beginning school has six teeth that already have started to decay. Over a fourth of the children have various conditions of crooked teeth that need attention.

Estimates are that cavities in children's teeth are increasing about six times as fast as they are being filled.

Careful studies made of large groups of children indicate that the use of sodium fluoride applications to their teeth could cut rates of tooth decay by as much as 40 percent.

NUTRITIONAL DISEASES

Dietary deficiency diseases in severe form—scurvy, rickets, and pellagra—are not so common among children as a decade or two ago. But they still exist, particularly among children of low-income families. Many more children suffer from general malnutrition, which causes them to grow at less than the normal rate and have less than average resistance to infections.

In some parts of the country, a recent study showed, as many as 72 percent of pregnant women and 85 percent of children of early school age were suffering from secondary anemia.

There are five ways to improve the diets of children: (1) Increase our educational work with mothers in mothers' classes, clinics, and public health nursing services in the home; (2) extend school lunch programs until they reach all children; (3) make sure that the right diets are provided in hospitals and other institutions; (4) im-

prove the nutritive value of staple foods, for example, by legislation requiring the iodization of salt and the enrichment of refined cereals and flour; and (5) remove discriminatory taxes which add to the cost of food, such as taxes on margarine.

Behind these nutrition programs for children should be a broad public policy to encourage both the production and consumption of the foods people need for good health.

Handicapped Children

The Nation's total of handicapped children has been estimated in millions.

Some 35,000 children have diabetes; 175,000, tuberculosis; 200,000, epilepsy. More than 175,000 children suffer from cerebral palsy—at least as many as are crippled by infantile paralysis. Half a million children have rheumatic fever and rheumatic heart disease—the chief fatal disease among school-age children.

Another half million have handicaps requiring orthopedic or plastic treatment. A million children have hearing defects, and 4,000,000 have visual defects.

Probably most of these children receive some medical attention during the acute stages of illnesses, but this is only one phase of the treatment they require. We have no plan for insuring that every child crippled by disease or injury is rehabilitated to the maximum possible degree. The cost is prohibitive to the vast majority of families.

A wide variety of services, well meshed together, is needed for handicapped children.

Some excellent demonstrations of what can be accomplished by well-planned services are going ahead in many States, with the help of Federal funds under the Social Security Act, but far more must be done.

Convulsive seizures in many epileptic children, the crippling effects of infantile paralysis, and progressive loss of hearing could be either prevented or greatly reduced by early recognition of the disease, prompt and proper treatment, and follow-up services.

Better obstetric care could prevent many birth injuries and many disabilities due to congenital syphilis. Sulfa drugs and penicillin may reduce crippling by bone infections. More aggressive accident control campaigns would help to reduce injuries.

The foundation for a thorough program of services already exists. What is needed is to build the first, second, and third floors over this foundation. That takes more personnel, more facilities, but above all—more money.

Tomorrow's Program For Children's Health

It is in the national interest that all children everywhere—regardless of race, color, religion, or economic status—should receive the same quality of good health service and medical care. Advances made in one area should be made available to all.

The speed with which we place medical care and health services within reach of every mother and child will depend importantly on the speed with which we accomplish our total health goals. Beyond this, it will depend on public funds for financing special services for mothers and children.

FINANCING SERVICES

Establishing adequate programs will require two parallel types of financing.

A part of the problem of financing child and maternal care is the lack of any system of Nation-wide insurance to make health and medical services available to everyone. Half of our children live in families that, in 1945, had incomes of less than $50 a week; almost half live on farms or in rural communities where, largely because income levels are low, health services and medical care are most inadequate.

Financing medical care will be best accomplished for children by a national system of prepayment for health services, supplemented by public health services.

Every State has made at least a beginning toward supplying the needed community services by setting up in its health department a special division devoted specifically to maternal and child health. No State has yet been able to supply all types of services required, or to reach all the children in need of care. Three out of four rural counties, for example, have no regular monthly well-child clinics—a minimal service.

Federal Grants

The Social Security Act in 1935 recognized the responsibility of the Federal Government for helping States and communities supply health care for mothers and children. But the Act, as amended in 1946, sets a ceiling of $11,000,000 yearly on grants for maternal and child health services and $7,500,000 for services to crippled children.

In May 1948 the States reported that for the year ahead, they could put to good use for crippled children $6,500,000 above the ceiling. At that time, 22,000 crippled children were on the waiting lists of State agencies.

The ceilings on present annual appropriations for the States should be removed for maternal and child health and crippled children services.

If present public programs were extended to reach all the child population in 1960, the cost—at present prices—would be about $430,000,000 a year. For this amount all communities and States would be able to offer well-baby clinics, immunization, home visits of nurses, school health services, and other special services such as are now provided only in our most fortunate communities.

Similarly, if public services for crippled children were extended to all handicapped children by 1960, the cost at present prices would be about $258,000,000 a year. This would provide for all handicapped children the diagnosis, treatment, hospital, and convalescent care that a limited number of such children now receive.

Expansion of these services is a responsibility of communities, States, and the Federal Government. All three should contribute.

EXTENDING RESEARCH

Along with the expansion of funds for services to children we will need an increase in research.

Premature birth is a major cause of death in infancy, and care to save the prematurely born infant is expensive. Compared with these costs, the expenditure for research is insignificant. There is urgent need for further basic knowledge as to causes of abortion, premature labor, toxemia, sterility, and fertility.

Research is needed into the causes of congenital malformations, of cerebral palsy, and other types of crippling conditions. A com-

panion study of the kind of community and family where these conditions occur should throw light on the kind of programs to meet these problems.

The Nation spends millions on children who are delinquent—an emotional illness in itself—and neglects research into the psychological and social factors behind juvenile delinquency. The interaction of a child and his environment is so complex that research in this field must call on the students of medicine, psychology, psychiatry, anthropology, sociology, social work, education, economics, and other sciences.

Types of needed research include the study of family as an institution. The family is undergoing rapid changes and we need to know their implications in the growth and development of children.

Personality and environmental factors behind various kinds of child behavior also require study. The history of behavior patterns of normal as well as of problem children, of impaired and handicapped children, would help explain the source of their problems and to improve parent-child relations. Early infancy is full of psychological problems for which our answers so far are largely in the form of theory and speculation.

chapter 9

Community Action

Eighth Health Goal

Planning and action in every community and every State, directed toward providing the best possible health conditions for all their people, by assuring adequate local supply of needed services, and by organizing the local agencies of health—doctors, hospitals, public health departments, voluntary groups—into effective teamwork for the welfare of the entire community.

All of the national programs for more manpower, more hospitals, for solving the special health problems and the economic problems of access to medical care, will be limited in their accomplishments unless the people of the States and the communities work together wholeheartedly for improvement of their own health.

The community effort is the spearhead of all Federal and State action for health. It is on the local front that national, State and community planning fuses into a single program, into a joint drive to improve conditions, to prevent individual sickness and disability and to save individual lives.

Federal and State Governments can provide, as they do, the resources and support to help eliminate tuberculosis and syphilis, for example, as causes of death and disability. Unless the local community takes energetic advantage of these programs—and it is in the locality that the initiative rests—little can be accomplished in that community. The 50,000 deaths that occur yearly in the United States from tuberculosis, the 15,000 deaths from syphilis, must be considered evidence that we fail in effective use of the knowledge that science has given us.

Thorough application of the techniques of sanitation and of proved methods of immunization—clearly a field for local action—could prevent more than 25,000 of the deaths that now occur yearly from various communicable diseases. Many thousands of needless

deaths from pneumonia, from childbirth and among infants can be prevented if proper medical care is available in the communities. In fact, our ultimate success in eliminating the causes of many of the preventable deaths that occur every year, in reducing the sickness and disability of which these deaths are a gage, will depend heavily on what the communities do.

Obviously, the communities do not bear exclusive responsibility in the phases of health work cited, or perhaps in any aspect of health. But the towns and cities, urban and rural communities, are key members of the Federal-State-community team. The role of each member of the national health team, and the area in which the communities carry the heaviest part of the load, will become apparent in the following discussion of the elements of good medical and health services in a community. The elements include ample medical manpower and health facilities, a fully effective public health department, strong voluntary health agencies, thorough coordination of services, and a sound financial plan.

A full development of all of these elements of good community health is essential in every locality of the Nation. The disparities within the country now are extreme. Local conditions range from very bad in impoverished areas—an almost total lack of all of these elements—to excellent for some groups within urban centers. Even those areas where services are best can work some improvement through vigorous and coordinated local action. Certainly, by taking advantage of the national program as set forth in this report, all can make significant gains toward better health.

The areas in which communities can accomplish the most are:

1. Surveys to estimate local deficits in personnel, facilities and services, and efforts to bring all available means—local, State and Federal—to bear on reducing these shortages;
2. Concerted action to establish local health units where they are lacking, and to bring all units up to full staff and full efficiency to provide a complete range of public health services;
3. Organization of existing health resources and services into effective teamwork for community health;
4. Joint planning by all organizations and citizen groups concerned with health and medicine to promote the welfare of the community.

Local Health Units

Ninth Health Goal

To establish everywhere local health units with full-time qualified staffs adequate to the needs of the population; to increase and improve the training of public health workers to the end that their numbers shall be doubled as rapidly as feasible.

Many essential services depend upon the existence of a local public health department and its efficient operation, as do various special programs.

Our national deficiencies in this field are extreme:

40,000,000 people in some 1,200 counties either without a public health department, or with departments that have only a part-time health officer;

96,000,000 people in the rest of the country served by inadequately staffed public health departments;

Only 7,000,000 people in the entire country served by public health staffs that fully meet the minimum standards laid down by experts in this field.

About 36,000 full-time public health workers were employed at the beginning of last year by the cities, States, and counties of the Nation—a little more than half the number necessary to bring existing local health units up to a minimum strength. Public programs to train additional workers will help, but public health workers are often poorly paid and work against other severe local handicaps. Unless local interest can be aroused to arrange better salaries and better working conditions, and to install effective merit systems, it is doubtful that there will be any great rush of students to prepare for these important fields. Community action is essential to this effort, as well as in assisting in the establishment of local health units where there now are none.

The greatest shortages, both of units and of workers, are in the rural areas of the country, where their services are most needed. It is emphasized throughout this report that services of all kinds are underdeveloped in most rural areas. In order to bring comprehensive services to rural people, effective coordination is essential. The

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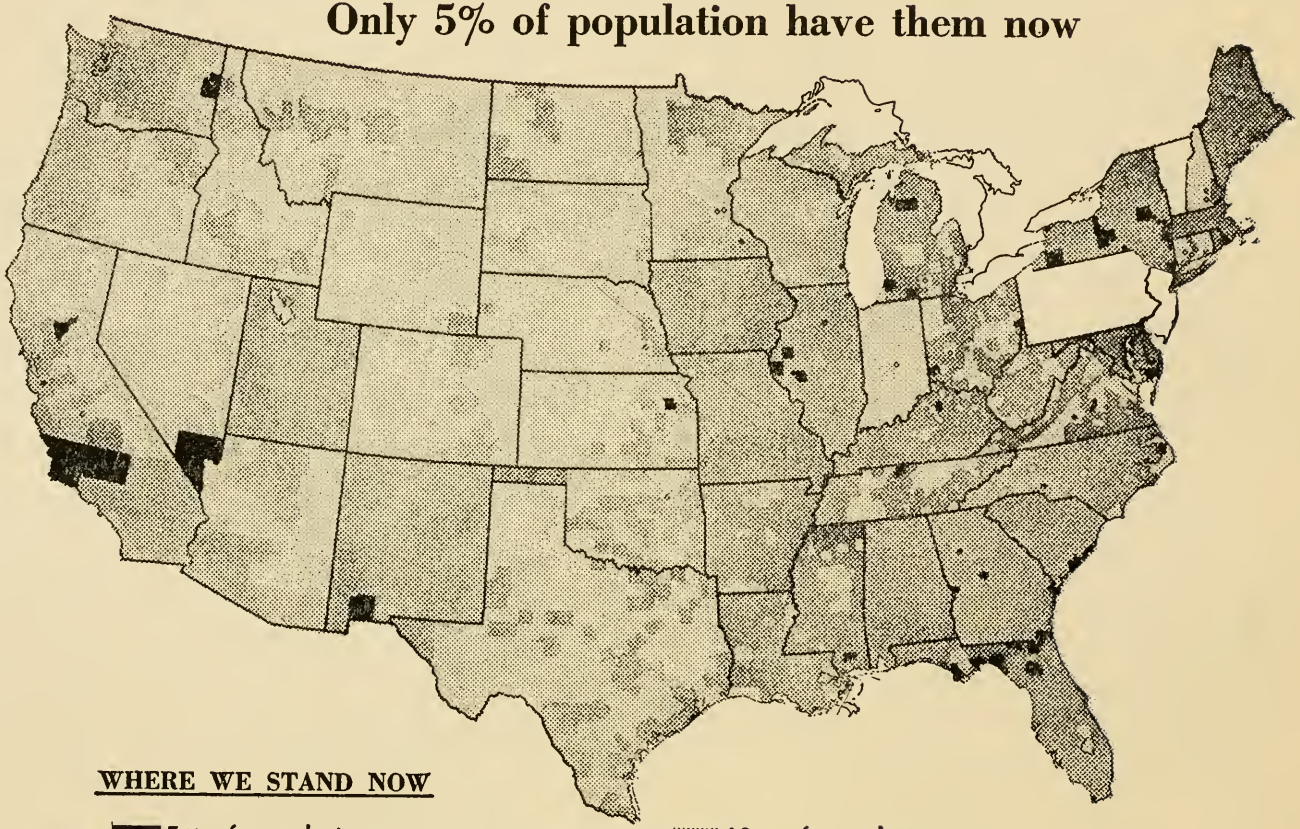
OUR GOAL: FULLY STAFFED LOCAL HEALTH UNITS

Only 5% of population have them now



WHERE WE STAND NOW

- 5% of population — Covered by fully staffed health units
- 60% of population — Covered by full-time health units
- 24% of population — Without local health units
- 11% of population — Not reporting: Pennsylvania, New Jersey, Vermont

local health unit is the logical official agency to be responsible for maintaining exchange of services with surrounding areas.

The family doctor and the staff of the health unit, together with its facilities for diagnosis, may well be the preventive medical team of the future in rural districts. The official public health agency would also be responsible for providing such services as mobile clinics.

The National Health Assembly's Section on Rural Health made, as one of its major recommendations, a plea for complete coverage of rural areas with adequately financed and well-staffed units.

I heartily endorse this recommendation. One hundred-percent coverage of rural counties with efficient public health departments would vastly improve the opportunities for health among farm and rural people.

City-county and multi-county units could do valuable work in many rural areas, but it is important that in such arrangements the interests of rural people should not be submerged to the special interests of urban groups.

HEALTH UNIT FUNCTIONS

The function of the local health units gives a valuable basis for estimating their importance and their local adequacy.

At the present time, the basic services which local health units should provide include: (1) community sanitation; (2) control of communicable diseases, including tuberculosis, venereal diseases, and malaria; (3) laboratory services for local physicians; (4) maternal and child health services, including school health supervision; (5) collection and analysis of vital statistics; and (6) health education of the public.

A staff to perform these basic services, plus the services themselves, would cost about $1.50 per capita of the population served. Thus, a county with a population of 50,000 would need about $75,000 a year to finance its local health unit. The medical officer would have a staff of 10 nurses, two sanitarians, a health educator, and three or four clerks.

Other Needed Services

If the Nation is to attain the health goals outlined in this report, the local health units will have to provide additional services and take on additional responsibilities.

Some of the new programs already planned or in operation in some areas include:

NUTRITION

Appraisal of the community's nutritional status; consultation with private physicians on the diagnosis of malnutrition and nutritional deficiency diseases; provision of nutritionists to advise families, schools, industrial plants, on diet and planning of meals.

DENTISTRY

Clinics for the preventive care of preschool and school-age children, pregnant women, and industrial workers.

CHRONIC DISEASE

Clinics for the diagnosis of cancer, diabetes and heart disease; consultations and postgraduate training for private physicians.

ACCIDENT PREVENTION

Appraisal of the community's accident hazards in homes, factories, hotels, hospitals, and other public places; correction of accident hazards; cooperation with State and local law-enforcement agencies for control of accidents, especially traffic accidents; organization of accident services for prompt transportation and hospitalization of injured persons.

BEDSIDE NURSING

Nursing care in the home of patients who need not or cannot be hospitalized; organization of community-wide nursing service for this purpose, including the use of practical nurses, nurse aides, and visiting housekeepers.

To provide the services listed here, in addition to the basic, traditional programs of public health, all local health units will need the following staff:

1 full-time medical health officer per unit
1 additional full-time public health physician for each 50,000 population
1 full-time nurse for each 2,000 to 5,000 population
1 sanitarian for each 15,000 population
1 health educator for each 50,000 population
1 clerical worker for each 15,000 population

Additional professional and technical workers for each of the special programs, in the ratio of one per 50,000 population, except that dentists, dental hygienists, veterinarians, and laboratory workers would be employed full time only in units that served at least 150,000 persons.

Twenty-eight States in 1946 had no nutritionists working in local health departments; 22 had no local public health dentists; and 36 were without community health educators, and many of the health educators on duty had not been trained for their jobs. Yet community health education is one of the basic requirements of a minimum public health program.

The deficiencies cited, and the importance of the task outlined, point to our national goals for public health units:

To organize, in all parts of the country that now lack local health services, new units which provide at least the basic traditional services and which have an adequate staff to perform their mission;

To bring all local health units up to the new standard so that they can expand their services for the benefit of the community.

FINANCING HEALTH UNITS

Financing is the key to accomplishing these goals. In 1946, approximately $67,000,000 was spent for local health services throughout the Nation.

Contributions were divided:

Communities	75 percent
States	6 percent
Federal Government	18 percent
Voluntary agencies	1 percent

The contribution of States is inadequate for the Nation as a whole. Eleven States made no contribution at all in 1946 to the support of local health units, and since that time only two of these have begun to lend assistance. The total contribution of the 37 States in 1946—amounting to $4,300,000—averaged 3 cents for every individual in the population served. Some of the richest and most populous States in the country provided only a few mills per capita to local health units. At the other extreme, Louisiana contributed 14 cents per capita, Delaware 13 cents, Kentucky, Florida, and Utah 10 to 11 cents.

It is clear that improved local health units will require larger contributions from many State governments. In some States, legislation will be necessary to permit communities to organize units for health work, or to unite among themselves for the establishment

of consolidated health units. The appropriate action will depend on the State and the community.

Federal Funds

It is probable that, even with the best efforts States and communities can make, adequate financing will not be available for fully efficient local health units throughout the country. This is the consensus of health authorities from the States and localities of the Nation.

I recommend, therefore, that the present system of Federal grants-in-aid through State health departments be expanded promptly, and that the Federal Government appropriate $250,000,000 for this purpose during the next five years. The appropriation should be increased promptly to $40,000,000 and by 1953 should rise to $58,000,000.

I wish, moreover, to endorse the recommendations of the National Health Assembly's Section on Local Health Units that every State health department make an immediate survey and stimulate civic planning to cover the entire area in its jurisdiction with full-time local health services; that each State health department develop a formula assuring equitable and nondiscriminatory State assistance to the various local areas.

HOUSING LOCAL HEALTH UNITS

Modern housing arrangements are essential to efficient operation of local health units. Many units are to be found tucked away in the basements of municipal buildings, and in even less suitable surroundings. State studies under the Hospital Survey and Construction Act of 1946 found in the entire country only 450 units—many within a single city—that were housed in acceptable centers. If we blanket the country with local health units, as we must if we are to achieve good health everywhere, we will need a total of about 5,000 such health center buildings.

The health center, in the terms discussed here, serves a dual purpose. It would provide offices for the local health unit but, especially in rural districts, it could also contain offices for private physicians and dentists and, in the absence of hospital facilities, a few beds for emergency use. The laboratory and other diagnostic equipment essential for clinical work would also be available for

private practitioners in the absence of other arrangements. The entire establishment would assist materially in providing for coordination of official and voluntary health services in a community.

There is every reason to believe that lack of decent quarters is an important reason that people fail to use fully the public health services that are made available to them through their tax funds. It can also contribute to poor service from local health units. Under the Hospital Construction Act, the Nation is planning to build some 1,900 health centers. This will make a beginning, but even when the initial construction program is completed, it will still leave us with fewer than half the total we need.

The expanded hospital construction program will include funds that may be applied to more rapid building of health centers to meet our national and local needs.

Organization of Services

The aim of organization is to bring all the locality's resources and facilities of medicine and health together as a cooperating team directed toward the single goal of improving community health. In many areas of the country, a start has already been made toward this highly necessary coordination. In a few, organization has been carried through to a high degree of efficiency. In still others, there is no such thing as a unified attack upon community health problems.

In localities of the last type, public health departments—if any exist—perform only certain limited tasks of preventive medicine and may carry on their work without reference to local voluntary agencies, hospitals, or doctors—and equally may be ignored, or even opposed, by other agencies of health and medicine. There may well be several voluntary groups directing uncorrelated attacks on various aspects of the same or closely related problems. Wasteful duplication of services, or grievous lack of them, may exist. Hospitals may be operating as wholly individual units and have no working arrangements with any other facilities.

Obviously, such a situation would be an extreme case. Between this and the well-organized communities are localities with all stages and degrees of cooperation among health and medical personnel. The need for a high degree of organization for health in localities throughout the country provides a fertile field for community action. The need for such work is pressing now as is clearly shown by the list of preventable deaths and all that it indicates in needless suffering and disabilities. In the future, thorough coordination of services will become even more imperative. There are two reasons for this: the changing character of health problems, and the increasing complexity of modern scientific medicine.

OUR CHANGING PROBLEMS

Most of the devices now used for prevention of communicable diseases are relatively simple and can be given mass application. Sanitation techniques applied to water, food and milk supplies, and to sewage disposal, require very little organization on the part of the general public. Immunization by means of injections, and

mass screening techniques for locating cases of tuberculosis and syphilis, require better organization and more public cooperation. Treatment in the latter cases is more difficult, often extends over considerable periods of time, and requires a combination of skills, facilities, and special medical abilities.

Our varying success against specific communicable diseases can be directly related to the comparative efforts made by community organizations to overcome a particular disease. We have been most successful in conquering diseases through sanitation, next most successful where immunization can be employed, and least successful where more elaborate techniques, coordination of services, and direct public participation are required. Obviously, organization is not the only factor in preventing premature deaths but the relationship nevertheless is significant.

It seems clear that to complete this unfinished business of health—the eradication of communicable diseases for which science has given us proved methods of prevention and cure—we need better organization of services. Other techniques for mass detection of dangerous diseases, or mass immunization and prevention, may be devised. The indications are, however, that further great progress toward better health will demand even more efficient organization.

Chronic diseases are the dominant physical health problem of the Nation for the years ahead. Preventive techniques as applied to chronic diseases primarily require early detection and arrest of the progress of the ailment. So far, the best preventive method known—as in the case of cancer—is through wide education of the public and through periodic health inventories that require diagnostic tests and access to specialists and various facilities.

This kind of medical work clearly requires a thorough organization of services and care. The methods and the system that worked 30 or 40 years ago when communicable diseases were the great killers—but which nevertheless have proved inadequate to complete the unfinished business of health—clearly will not be able to meet our needs for the future.

COMPLEXITY OF MEDICINE

Not only do the health needs of the people require changes in the system of medical and health services, but the developments

of scientific knowledge and of medical techniques also require a realignment of organization.

The individual doctor can no longer master the entire field of modern medical knowledge, any more than he can carry in his car the full diagnostic and curative equipment of modern medicine. The development of specialists has been a natural and desirable result. But specialized services must be coordinated if the patient is to receive a maximum benefit, and if doctors are to accomplish the greatest possible results. A careful and rational plan is necessary also to correlate the findings of such adjuncts of modern medicine as microscopy, radiology and chemical analyses in prevention, diagnosis and treatment.

These developments have combined, also, to increase the capital investment necessary for adequate health services. Hospitals cost about $10,000 a bed to build, at current prices, and about a third that amount for each year's maintenance. Each physician's investment in education and office equipment is supplemented by a public investment—through taxes and gifts—of about $30,000 per doctor, utilized by them in their hospital practice.

All of these facts point to the imperative need for community and State action, to achieve among the individuals and groups who work for health that close teamwork which alone can assure successful modern medicine.

ELEMENTS OF COORDINATION

Organization of medical and health services, in the terms discussed here, will require cross-coordination of many separate elements. The necessary steps include:

1. Coordination of the knowledge and skill of professional personnel in all phases of health or medical work;
2. Coordination of hospital and other health facility services so that patients can obtain, through referral if necessary, all care that they need;
3. Central listing, and scheduling for full utilization, of all scientific apparatus;
4. Central listing of all qualified health facilities, hospitals, nursing and convalescent homes;
5. Professional management, with public participation, of

hospitals, clinics, and health departments for community benefit and for maximum efficiency and economical use;

6. Cooperation among all health agencies—private, voluntary, and public—in a locality, State, or region to prevent duplication of effort and to assure effective functioning;

7. Full participation of professional, civic, and consumer groups in community and State planning that will focus on community problems from the standpoint of whole community health and, from this vantage, to stimulate necessary effort, fill in gaps in the total program, and assure the necessary financial and political support for accomplishment of determined goals.

The Standards

Implicit in all efforts toward organization of services is emphasis upon high standards. Five points, not necessarily all-inclusive, which are important in this effort are:

1. The quality of professional services must be high. This requires adequate incentives to professional personnel, encouragement of personal contact in diagnosis and treatment—that is, maintenance of the doctor-patient relationship; and an opportunity to prescribe all necessary tests and treatments without being limited by economic factors; also, an opportunity for doctors to keep abreast of science through refresher training;

2. Complete services for all types of illnesses or conditions should be available and accessible to everyone under conditions that encourage their use, without limitation because of personal finances or discrimination because of race, color, or creed;

3. Professional cooperation should be stressed rather than economic competition, which should be limited to efforts to improve the quality and amount of service given;

4. Incentive to control costs is important, but this should be accomplished by efficient organization of services so as to conserve time, effort, and materials rather than by lowering quality;

5. Emphasis should be on preventive methods rather than solely upon the cure or relief of illness.

Hospital Integration—An Important Program

The importance to better health conditions of close working relationships among the hospitals of a region or State can scarcely be overemphasized. In its simplest form, this plan calls for large medical centers, particularly those connected with medical colleges, to provide various services to smaller nearby hospitals and professional personnel, for patients who require special care. At its greatest development, the plan would establish a system of hospitals and health centers throughout the region, graduated to fit local needs and closely integrated with the medical center and college for all types of joint services and health promotion.

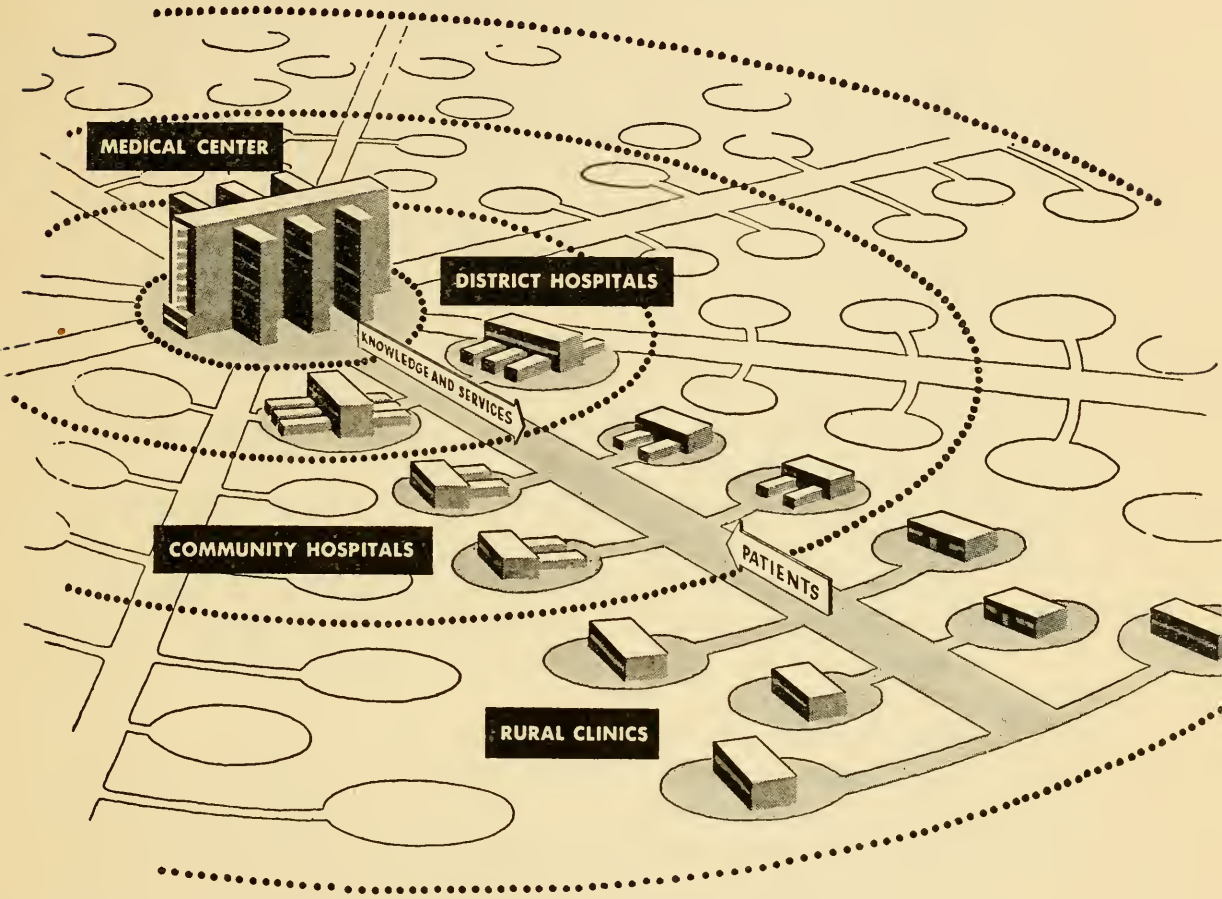
There are a few pioneer programs of this general type in existence already, notably the work of the Bingham Associates with Tufts Medical College, the work of the Long Island College of Medicine, the University of Chicago Hospital Clinics, the Minnesota State Plan with the State University Medical School as its center, and the Rochester, N. Y., system. Much administrative planning and experimentation would be necessary in individual States and communities before the most efficient method for a particular region could be devised.

As worked out by the Public Health Service, and included to a degree in planning under the Hospital Construction Act, an effective regional system of hospitals would include four major elements—the base hospital or medical center, the district hospital, the community hospital, and the community clinic. Under this plan each major element of the system would be linked administratively to the others. (See chart, Better Hospital Integration Means Better Health.)

Base Hospital

The base hospital or medical center would be the nucleus from which radiates the highest type of medical care out to the smallest community, even to the lonely farmhouse. There should be at least one such hospital in every State, preferably associated with a medical school and other professional training centers. The base hospital would combine training, medical research, and expert diagnosis and treatment of complicated cases and would provide refresher training and extension services to keep doctors abreast of

BETTER HOSPITAL INTEGRATION MEANS BETTER HEALTH



A COORDINATED HOSPITAL SYSTEM, through a free-flowing exchange of medical services and patients, would offer the highest quality medical care to all communities, even the most remote. The *medical center* would combine training, extensive research, expert diagnosis and treatment of complicated cases. Several *district hospitals* would provide such general and special services for most hospitalized patients as major surgery, pediatrics, obstetrics, psychiatry. *Community hospitals* would offer more limited services, referring more complicated cases upward. *Rural clinics* would serve chiefly as out-patient clinics and diagnostic centers for referral to the larger hospitals.

science. A base hospital would serve several district hospitals and an even larger number of community hospitals and rural clinics.

District Hospital

The district hospital would be the intermediate element in the system. Several district hospitals in fair-sized cities not only would provide nearly all types of services for patients in their communities but would also admit patients from the smaller community hospitals for study and treatment. Major surgery, pediatrics, obstetrics, internal medicine, psychiatric service and care of chronic disease patients would be available either within its walls or in closely associated institutions. The district hospitals would also be important centers for intern and nurse training, for consultant services to physicians and hospitals in outlying districts. In some areas lacking medical schools a large district hospital might serve as a base hospital.

Community Hospital

The community hospital would be the third element in the plan; smaller in size than district hospitals, it would serve a smaller population group. Located usually in a small community, such as a rural county seat, it would serve chiefly a rural and local urban population. A more limited type of service would be provided here, but, because of the organization of the entire system, the community hospital could actually provide its patients with complete service of the most complicated types through affiliation with district and base hospitals.

Rural Community Clinic

The rural community clinic would serve outlying areas that frequently are too remote from community hospitals. In many instances the rural community clinic would be jointly housed in a health center with the headquarters, or a branch, of the local health unit serving the area. Here the local health unit would hold special clinics—prenatal and well-child clinics; mental health, orthopedic, and cancer clinics. Here also would be available to the family physicians of the area basic diagnostic services such as laboratory and X-ray analyses. In extremely isolated areas the rural community clinic might have a few hospital beds for emergency cases. But in relation to hospital care, it would serve chiefly as a diagnostic clinic or out-patient center for referral of patients to larger centers of medical and hospital service.

One of the greater contributions which the coordination of health and hospital services could make would be an increase of diagnostic facilities. Well-equipped diagnostic clinics could be established in local health centers or in community hospitals.

At the present time there are very few parts of the country where a patient can go to a single place for the battery of diagnostic tests and examinations needed to conduct a thorough health inventory.

In rural areas and most small-sized urban communities, family physicians cannot afford such equipment and service. A diagnostic center to which physicians could send their patients for a careful checkup would greatly advance the health of a community. More accurate diagnoses could be made promptly; and, therefore, more effective treatment could be instituted promptly. More young physicians would be attracted to practice in rural and small urban communities if they could be assured of adequate facilities.

In many areas, particularly in larger cities, this type of coordinated service would be hampered by the fact that many doctors are not on the staffs of hospitals and nonstaff doctors are not permitted to use hospital facilities. In some cities as many as half the doctors are not admitted. To make full use of diagnostic facilities, and to provide fully effective services for the people of the communities, all qualified doctors should have staff privileges in hospitals.

Medical College

Under a system of hospital integration as described, a medical school hospital would have many new functions, including organized collaboration with local physicians and hospitals. All physicians associated with any part of the system would have access to consultative, laboratory, and educational facilities of the center. Teams of specialists could be sent from the center to outlying areas to conduct clinics or seminars on new methods. A local physician who wished to undertake postgraduate study could be supplied with a substitute doctor by the medical centers. Medical students also could be assigned to district and community hospitals and rural centers for clinical and administrative internships.

The quality of care received by the people in the region would be substantially improved by such an integrated program. The influence of up-to-date methods and techniques, of expert clinicians

and investigators, would be felt by all the affiliated services and by all professional and supporting personnel.

The position of the medical college as the center of this orderly plan for expert medical and hospital care suggests that the school might become an important agency for the State-wide coordination of medical and hospital services.

Better Health Services Through Group Practice

Many of the benefits in quality of service and in care of patients that can accrue from hospital integration are provided by group practice, modeled on the great private medical clinics of the country. Group practice also promotes scientific inquiry and critical exchange of opinion and experience among professional people and provides patients with access to consultative, thorough, and scientific medicine.

There are at present some 400 to 500 groups of this sort in the Nation with as few as 3 or as many as 500 doctors in a group. From the standpoint of the providers of medical service they offer an opportunity to pool expenses for offices, equipment, and supporting personnel. Establishment of such group enterprises, with facilities financed by local public organizations, probably offers one of the best means of making adequate medical services available to rural towns and districts.

The initiation of group practice, the accomplishment of hospital integration, depend primarily on the willingness of private practitioners of medicine and of hospital administrations and staffs to enter into such arrangements. The organization of widely representative planning and action groups in States and communities can accomplish more than any other single step to bring about this essential cooperation and to provide coordination of services for the benefit of the people.

Community and State Planning

The goals for community and State action can be fixed only by the people of each individual community and State. They alone can initiate the surveys to determine local health conditions, can measure the deficits of services and resources against their need, and take the necessary steps to organize local services and to get the maximum advantage from the national program.

The goals fixed for a locality will depend first of all upon what services already exist and how they are organized to meet local health problems. But, regardless of what they are, the path to action is the same—a local or State planning group that includes the business and social groups, labor unions, civic clubs, farm organizations, physicians and other professional people, voluntary health agencies, public health workers, and representatives of all people affected by the planning.

Community Planning

Excellent advances have been made by this means in communities and States scattered over the country. In many situations, the interest of the community in a specific problem was stimulated by voluntary health agencies. More than a dozen examples of community enterprises were studied and analyzed by the National Health Assembly's Section on State and Community Planning. All have achieved widespread public interest, participation, and support both among professional groups and among consumers of health services. All have achieved better coordination of health services and greater cooperation among local, State, regional, and national groups concerned.

Specific accomplishments of the planning groups vary with the length of time they have been working and the particular goals to which they addressed themselves. In Ohio, the Miami County Mental Hygiene Association was able in a relatively short while to have a mental hygiene clinic established. In Cincinnati the Public Health Federation instituted an educational campaign to cut down deaths in connection with appendicitis operations and achieved its objective. It also successfully sponsored bond issues for a new chronic disease hospital, for improving the City Hospital, and for

rebuilding the Tuberculosis Hospital. A general clinic for Negroes was established; a central mental hygiene clinic and programs in cancer control, diabetes, heart diseases, and nutrition developed.

In North Carolina the Buncombe County Association for the Handicapped and Health Services got the local health department to employ a full-time trained community health educator to assist in planning and developed workable plans for a mental hygiene clinic and a cancer clinic.

State Planning

At the State level the Virginia Health and Medical Care Council helped achieve a number of legislative advances in 1946. The Health Department appropriation was increased by nearly $2,000,000; rural scholarships in medical schools were increased; around $2,500,000 was obtained for capital outlays on tuberculosis hospitals; and $9,000,000 for hospitals for the mentally ill. Provisions were also made for a hospital survey and for a legislative committee to conduct further health studies.

Colorado has achieved a reorganization of its State Health Department and legislation to enable counties to have full-time local health units under the leadership of the Colorado Subcommittee on Health of the Governor's Postwar Planning Committee. This was accomplished through a loosely organized group of actively cooperating agencies and societies in the State. In addition, Denver was helped to obtain a strong and ably directed health department.

The Illinois Statewide Public Health Committee grew in its first six months from an Executive Board of about 50 people to an organization of several thousand members and friends, with many affiliated county committees. They sponsored and obtained legislation to permit the establishment of county health departments. The bill was enacted within the year without a dissenting vote. Since then, local committees have helped establish county health departments.

Regional Planning

At the regional level the Great Plains Committee on Rural Health and Welfare has stimulated public concern and study on how health facilities may be adapted to rural needs and has located rural health specialists in each of five States of that region.

Planning and Action —A Citizens' Project

Successful planning-action councils have one thing in common—they have sought and obtained the widest possible public support of their programs. Consumer and civic groups have worked with professional organizations and participated fully in the projects of community and State planning.

Wide participation of all interested groups is so important that it well might be called the first requirement for successful health work. Planning progresses through educative campaigns, through enlisting the active cooperation of large numbers of people. Without the deep interest and involvement of large numbers of representative citizens working together to study and correct health problems, such functional civic planning cannot take place. Without enthusiasm and support among all groups of people throughout the area involved, the necessary financial and legislative action cannot be obtained.

This type of action is needed throughout the country to carry forward the national program for better health. People in every city and town, every farm and rural village, should be reached if such community programs are to succeed fully. The area served by the planning council may include only a neighborhood or other special group within a large city; it may comprise a metropolitan trade area, the city and its surrounding rural area, a district of several counties, a whole State, or even a region including several States.

The people of the Great Plains, for instance, undertake health plans together because of their common problem of providing rural areas with adequate medical, hospital, and health services. Of their nearly 6,000 villages, towns, and cities, almost 5,000 have populations of fewer than 500. Only about 200 towns have 2,500 people or more. This planning group is seeking to design facilities that will give the most service to a widely scattered population, will provide stable incomes for physicians, and will tie in their services with larger and more complete health and hospital centers.

THE BEGINNINGS

Community planning has usually started when some local problem arouses concern. In some instances, consumer and civic groups have taken the initiative; in others, professional people.

Among problems that have stimulated action were the local need for coordination of health services, for medical care and sanitation, for a full-time local health unit. When an individual or group is aroused to seek a remedy, both consumers and experts in health are usually called in for preliminary discussion to ask and answer key questions. Attention is given to the way the unsatisfactory health condition affects all groups in the area, all races, all economic levels, and to what can be done to benefit them all.

The planning group organized as an outgrowth of discussions may be called a board, a committee, an association, a council. It may be a special organization or a subsection of a civic or social planning council. But regardless of designation, all successful health planning groups are essentially citizen health councils which, as the title implies, operate for the direct advantage of all the citizens.

When a council has been organized as an outgrowth of discussions, a successful program for health will include the following steps:

Survey

Painstaking inventories of all the resources available for the purposes of health—funds, facilities, manpower, services, organizations, and public awareness of the health situation.

Evaluation

A critical balancing of the books, resources against needs, in relation to the health goal set by the representatives of the area's professional and consumer groups together.

The Plan

The imaginative reconstruction of resources by the broadly representative planning body and the projection into the future of what will be needed, both in supply and organization, to attain the goals.

Action

Public interpretation and health education combined with constant efforts to increase people's participation in the planning, so that the plan may be adopted by the entire population group concerned and through their support—financial or political—be translated into action.

Appraisal

Systematic resurvey and reevaluation of the plan in operation to keep it flexible, with alterations to suit the changing needs of

the people, or to take advantage of new scientific knowledge or new developments in administration.

How Can We Assure Community Action?

The scope of this report does not permit more detailed discussion here of the processes of State and community planning, but extensive treatment has been given to the subject in the report of the National Health Assembly's Section on State and Community Planning.

At present, as this discussion has indicated, the beginnings of community planning and action for health are somewhat haphazard and depend more or less on chance personal or group interest in an immediate problem. The local programs that exist have made notable accomplishments and will, I am sure, go on to improve their community health still further. But, even in their aggregate, these plans cover a very small part of our Nation and meet only a fraction of our total need. It seems obvious to me that the Nation cannot boast a single area—city, county, State, or Territory—in which there is no room for further improvement. This report has clearly shown that large areas and considerable population groups lack many of the basic services for minimum health.

As matters now stand, these communities must wait upon the chance awakening of interest in some local problem to fire a community into action. Probably if a sufficiently grave epidemic or other health calamity struck any one of these communities, a competent volunteer leader would arise and planning would be launched. It does not seem wise, however, to leave such important work to tragic happenstance when prudent forethought not only can accomplish the same ends but also perhaps avert the danger of calamity. The national interest, as well as that of the communities of the land, demands a more positive approach.

The processes through which planning normally passes suggest a remedy. Sooner or later each planning group seeks the continuous guidance of a worker trained in public health and community organization, generally designated as a health educator. The planning bodies in Illinois and in Buncombe County, N. C., obtained the services of health educators on loan from their State Health

Departments. The Cincinnati organization employs its own full-time specialists. The Miami County Association, too, has engaged a health education expert.

It is scarcely necessary to say that the health educator must be a highly competent individual, informed in health matters but especially skilled in working with citizen groups. His task is not to plan but to stimulate and to give valuable assistance to organized groups of professional and consumer representatives, to citizens interested in health. His function, in some important respects, parallels the educative work that agricultural extension specialists perform.

A HEALTH EXTENSION SERVICE

An extension service for health, comprising health educators attached to local, State, and Federal health agencies, could perform invaluable service in helping communities and States to organize citizen health councils. Such a service, I believe, would do much to assure the success of the national program for better health and to help communities make good their deficiencies in resources and coordinate their health services.

As a Nation we would probably need one health educator for every 50,000 population—a total of some 2,800 workers. Voluntary agencies and schools will need hundreds more. We should be able to train enough workers for effective extension services in considerably less than the next 10 years if we move promptly and forcefully toward this end.

To expand the extension service for health, and to assist State and community planning, therefore, it is recommended that increased Federal-State grants be authorized for public health training facilities and for trainees, so as to increase as rapidly as practicable our supply of health educators, to the end that every public health department shall be staffed to help citizens in forming and operating citizen health councils.

Teamwork for Health

During the war the people of the Nation rallied to every cause that would promote the national interest and security. More than 7,000,000 people, for example, worked with the Red Cross; more than 20,000,000 in civilian defense work.

To my mind, the need for volunteer workers for national health presents a cause that should call for an equally great outpouring of effort. Our goal is nothing less than the saving of hundreds of thousands of human lives and the prevention of human suffering—the promotion of optimum health. Through organization in every city and town, every village and hamlet, rural district and State, we will be able to see the concrete results of our effort.

The targets for local action will be as varied as the towns and countrysides in which they are found. No effort on a purely national scale can possibly locate the problems or know the best means for overcoming them. That is a job that must be done, that can only be done, by the people themselves in their own homes and in their own communities, through the type of democratic action that has made this country strong and on which it must always rely for growth and expansion.

In concluding this discussion of the needs, the ways and means, of community action, I want to appeal as strongly as I know how to people everywhere—all the people—to start asking questions about their local health conditions. If enough people will take up the challenge of health and demand action of themselves and of their neighbors, we can hope to see the day when no individual anywhere in this country suffers or dies because his community, his State, has failed to do its utmost in his behalf.

This Nation owes its very beginnings to the inspiration and the drive of the people. They are the strength, the resource of our national existence—and health is their own most precious resource as well as the foundation of national security and prosperity. In addressing the National Health Assembly here in Washington at its sessions in May, I urged all its members to try when they returned to their homes to stimulate a renewed effort in their individual communities and States. I know that the delegates will do this of their own initiative, but this is something about which I feel so strongly that I feel I must say it again.

A popular movement for health, planning for health, working together for health, is in the last analysis the only way in which we can raise the standards of health in our own communities and for the Nation. Health is not the private concern of a few individuals or a few institutions—it is everybody's business. It is particularly the business of the consumers—the patients—the people who must demand the best for themselves and for those dependent upon them.

If the people will get together—professional workers and public representatives alike—in citizen health councils throughout the country, we will have the satisfaction of proving not only that health is everybody's business but that it is good business, essential business, and successful business.

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